

PSYCHIATRIC NURSING DESCRIBED: An investigation
of the role of the psychiatric nurse using
Flanagan's critical incident technique

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ERRATA

Please note the following errors on pages 40, 226c and 232.

On page 40, paragraph 3, line 1 add the word "a" between "construct" and "twelve".

On page 226c, paragraph 4, line 1 delete the word "work" and substitute "results".

On page 232, paragraph 3, line 2 delete the word "does" and substitute "do". Line 3, delete the word "it" and substitute "they".

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ABSTRACT

The major aim of this thesis was to describe the work of six grades of ward-based psychiatric nurses. The major data collection tool used was Flanagan's critical incident technique. Four thousand, four hundred and seventy seven incidents were collected from 1,637 staff and patient respondents in eleven Scottish psychiatric hospitals. 58% of the incidents related to effective nursing activity, 42% related to ineffective activity. Critical incidents were inductively classified into a three-level system consisting of areas, categories and sub-categories constructed by the writer.

The classified critical incidents were used to describe the work of the psychiatric nurse and to examine the differences and similarities among the six nurse grades, day and night shifts and among the geriatric, long-stay ambulant and acute nursing sub-specialties. Differences among grades, shifts and specialties were found to be minimal and in terms of emphasis only.

A second type of data was collected, namely training programmes, job descriptions and assessment schedules. These were compared with each other for consistency of content, and with the description of the work of the psychiatric nurse derived from the critical incidents. Comparisons showed considerable differences between what nurses actually did, what they were trained to do, the content of their job descriptions and the criteria on which their clinical assessment was made.

The implications of the above findings are discussed in relation to nurse education, practice and professionalism. A framework is presented for use in relation to;

- (i) patients' potential nursing needs
- (ii) evaluation of nursing care
- (iii) educational needs of ward based psychiatric nurses
- (iv) assessment of ward based psychiatric nurses

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CHAPTER 1

INTRODUCTION

Health care provision continues to utilise a large part of Government expenditure in the United Kingdom, the cost of hospital services constituting a significant part of the total health care budget. In turn, a large part of the total expenditure is used to pay staff salaries, including nursing staff. According to a recent report (Information Services Division, Common Services Agency For The Scottish Health Service 1979) hospital services in Scotland cost £468 million to operate in 1977-1978, including £338 million for staff costs. Salaries for nursing staff were greater than for any other staff group, £159 million, and constituted 47% of total staff costs in the 1977-1978 period.

Thus there is a strong economic motivation for pursuing an enquiry which will yield data relating to the role, functioning and effectiveness of nursing staff employed in the National Health Service. There are, however, other professional and ethical considerations which make an examination of the role of the nurse more imperative.

Firstly, there is the general responsibility which any professional group must have to possess a knowledge of its own function, in other words, to know and be able to describe what the professional role involves. On one large group of professional nurses, Health Visitors, Clark (1976) wrote:

"There is no shortage of opinions about what the role of the Health Visitor should be; There is, however, a dearth of factual information about the content of the present work of health visitors." p 25

Three years earlier Scott-Wright (1973), made an even more sweeping claim about what was known regarding the objectives of the nurse; she wrote:

"The plain and awkward truth is that almost nothing is known about it in a profession that has had neither the opportunity nor the inclination to pursue it scientifically." p 216

There is increasing evidence to suggest that other groups of nurses are becoming more aware of the need to define their role, for example Nursing Times (1980) reported that the "uncomfortable" question of what the role of the nurse in the operating theatre is, required to be answered.

The lack of role definition which applies to the nurse generally has an equal relevance to that of the psychiatric nurse. Caudill (1952) described the role of the nurse caring for neurotic patients as being "vaguely defined" and, by virtue of the vagueness, anti-therapeutic. Jensen (1960) viewed the lack of clarity of the psychiatric nurses' role from an educational viewpoint and referred to the inability to identify features of nursing competence as "perplexing". Carl (1961) suggested that psychiatric nursing research should be addressed to answering the question "what are the characteristics of psychiatric nursing?" Lambersten (1965) was critical of the inability of nurses to evaluate the quality of nursing care, claiming that "good patient care" remained an abstraction, and that the components of nursing care had yet to be identified. Nicholas (1969) having posed the question "What should mental nurses be doing?" concluded that;

"..... it is really an area of ignorance We do not know, for instance, what constitutes a successful nurse." p 1273

Callista (1970) implied that nurses were failing to keep pace with other areas of health care because of a difficulty in identifying their own area of practice. More recently, Denny and Denny (1980) were critical of the apparent lack of planned nursing care and specific nursing objectives in relation to the mentally ill. Sladden (1979) in a major study of the role of the psychiatric nurse in the community reported that;

"The situation of the community psychiatric nurse as observed during the study showed a number of ambiguous and incongruous features, and was characterised by a lack of a fully legitimate role in the community setting." p 177

This lack of awareness of the role of a professional group raises a number of problems, not least the one relating to which areas of a role to keep, discard or change in favour of the adoption of new role elements.

Following an examination of the prescribed and observed roles of the psychiatric nurse Cormack (1975) recommended a thorough examination and evaluation of the present contribution of the nurse. Because that study formed much of the background to the work reported here, an abstract from Cormack (1975) is presented below.

"This study describes the work of the charge nurse in acute psychiatric admissions wards from three viewpoints and attempts to provide quantitative and qualitative data relating to the work of the nurse.

"The first view was taken from opinions and statements appearing in recent literature, and relating to the role of the psychiatric nurse. One hundred and thirty texts were consulted and the roles prescribed by the writers categorised. The vast majority of writers placed the psychiatric nurse in a role which demanded formalised psychotherapeutic or relationship therapy skills.

"The second view of the nurse was prepared from data collected during 168 hours observation of fourteen charge nurses in a sample of acute admissions wards of four Scottish psychiatric hospitals. Observation indicated that the nurse was not filling the formal therapeutic role in which many writers placed her. The role of the nurse, as evidenced by nurse/patient interaction, indicated a predominantly progress monitoring function.

"Ninety-six patients in the wards visited by the writer provided the third view of the psychiatric nurse's role. Those patients who did view the nurse as being a positive contributor in the treatment plan, perceived the ability of the nurse to help as being contained in the personal qualities of the nurse, rather than in their ability to function as formal therapists. Nurses were commonly described as being warm, friendly, cheerful, sympathetic, understanding, kind and non-judgemental.

"It was concluded that while nurses were not observed to be filling the formal therapeutic roles prescribed in much of the literature, many patients indicated that they found

the present nurse's role of value. It was suggested that before any move is made to substitute the present role of the nurse with a more formalised therapeutic role, a thorough examination and evaluation of the present therapeutic contribution of the psychiatric nurse be made."

p ii - iii

Secondly, the existing role of the nurse may, in part, be harmful to the patient in that it can cause "disease" or hinder the process of recovery. The general name given to the process by which agencies which are designed either to prevent or minimise disease, in fact cause or maximise it, is "Iatrogenesis". The American Psychiatric Association (1975) defined Iatrogenic Illness as

"An illness unwittingly precipitated, aggravated, or induced by the physician's attitude, examination, comments or treatment." p 64

However, this view is narrow in that it fails to take account of the others, including nurses, who may cause iatrogenic disease. Barton (1976) described the iatrogenic disease "Institutional Neurosis" as being induced largely by hospital staff, including nurses. He described institutional neurosis as;

"..... a disease characterised by apathy, lack of initiative, loss of interest, especially in things of an impersonal nature, submissiveness, apparent inability to make plans for the future, lack of individuality and sometimes a characteristic posture and gait." p 76

He goes on to describe the possible causes of the illness as being loss of contact with the outside world, enforced idleness and loss of responsibility, brutality and teasing, bossiness of staff, loss of personal friends and events, drugs, ward atmosphere, and loss of prospects outside the institution.

Not only may staff behaviour cause patient pathology, it may also sustain pre-existing pathology. For example, the writer is familiar from personal experience with the tendency of inexperienced and experienced nurses to encourage patients' delusions and hallucinations by spending much time prompting

patients to verbalise them. Much of the success of recent applications of operant conditioning techniques in the treatment of the mentally ill is due to the realisation that hospital staff, including nurses, had earlier been encouraging, or causing, abnormal behaviour in patients. For example Smith and Carlin (1976) instructed staff to:

"..... ignore the patient's dramatic crying, tantrums, and stereotyped behaviours, but to pay attention to her when she expressed feelings in other ways." p 144

The writers go on to describe a patient displaying psychotic behaviour who was being rewarded by:

"..... getting some of the medication and attention she demanded from the nurse, thus actually increasing the frequency of the behaviour." p 145

Thirdly, in health care systems generally, an increasing awareness of professional accountability is being recognised. Not only are professional groups increasingly expected to anticipate and describe the outcome of their contribution, they are increasingly being expected to define and describe that contribution. Bergin (1971) recommended a research approach which:

"should be directed towards answering what treatment, by whom, is the most effective for this individual with that specific problem and under which set of circumstances." p 253

Finally, an understanding of the role of the psychiatric nurse is an essential prelude to determining what should be taught to those being educated to fill that role. Bendall (1975) in a discussion of the considerable gap between theory and practice in nursing concluded that;

"The first and most pressing need is for research into what should actually go into a nurse training syllabus, in terms of what happens in the ward situation." p 68

Mager and Pipe (1970) discuss further educational input as a possible solution to the problem of inadequate or inappropriate staff performance, a solution which has been previously favoured in relation to nursing. However, these writers go on to suggest that

such a course of action may be premature since it focuses attention on a solution, rather than on defining the underlying problems.

It is being suggested in this study that examination of "what psychiatric nursing is" is of more immediate importance than how to prepare psychiatric nurses. It is also being suggested that a knowledge of what psychiatric nursing is must precede a discussion of the required educational input.

The above reasons demonstrate that, apart from economic considerations, the need to continue to investigate the role of the nurse is of vital importance both from the viewpoint of patient care and an understanding of the nature of nursing and its educational requirements.

The major objective of this study is to describe the role of ward based psychiatric nurses and to examine differences between shifts, specialties and nurse grades. A further four related aims are;

- i) to obtain an objective basis by which to assess patients' nursing needs
- ii) to formulate criteria by which to measure the effectiveness of the work of the psychiatric nurse
- iii) to provide an objective appraisal of the educational needs of the psychiatric nurse
- iv) to provide a basis for an objective assessment of nursing performance.

CHAPTER 2

NURSES AND NURSE EDUCATION

Unlike some other countries, for example the United States of America, nursing in the United Kingdom is performed by a number of distinct groups of nurses caring for a variety of patient groups. The General Nursing Council For Scotland maintains one Register to which there are four parts, each part containing the names of a specialist group of nurses.

TABLE 1

| Four parts of the Register maintained by the General Nursing Council For Scotland | |
|---|----------------------------|
| NURSE REGISTRATION | TYPE OF PATIENT CARED FOR |
| Registered Mental Nurse | The mentally ill |
| Registered General Nurse | The physically ill (adult) |
| Registered Nurse for the Mentally Defective | The mentally defective |
| Registered Sick Children's Nurse | The physically ill (child) |

Nurses in each of the above four specialties undergo a training which qualifies them to work in that specialty. The General Nursing Council for Scotland also maintains the Roll which contains the names of enrolled nurses. The Roll does not, as is the case in England, have specialist parts depending in which specialty the nurse has been trained. The principal concern of this study will be the role of the psychiatric nurse, including the Registered Mental Nurse and the enrolled nurse. The care of the mentally ill continues to feature largely in the National Health Service in terms of the number of in-patients and the number of nurses required to care for them. According to the Information Services Division Common Services Agency for the Scottish Health Service (1979) 30% of in-patients in the 1977-1978 period were in mental hospitals.

"Nurses" is the generic name given to a number of staff who deliver minute-to-minute care to "patients", the term also covers those nurses who function as nurse administrators. FIGURE 1 is a representation of a typical nursing structure in Scotland and includes the clinical element, nursing assistant to charge nurse, and the administrative element, nursing officer to chief area nursing officer. The subjects of this study will be the grades of nurses who provide direct patient care, the clinical grades. For the purpose of clarification and future identification in this text, each of the six clinical ward-based grades of nurses is briefly described below; each grade also being identified by a number (1 - 6).

1. Nursing assistant (Grade 1)

The nursing assistant has had no formal training, her function being to assist other members of the ward team. She may have had an "informal on-the-job" training but will have learned her nursing skills largely by practical experience.

2. Pupil nurse (Grade 2)

The pupil nurse is engaged in a two year training programme prescribed by the General Nursing Council for Scotland. On qualifying she will become an enrolled nurse (see 4 below) and will have her name added to the Roll which is maintained by the General Nursing Council for Scotland.

3. Student nurse (Grade 3)

The student nurse is engaged in a three year training programme prescribed by the General Nursing Council for Scotland. On qualifying she will become a Registered Mental Nurse and may immediately occupy a position of staff nurse (see 5 below).

4. Enrolled nurse (Grade 4)

The enrolled nurse has trained for two years as a pupil nurse (see 2 above). Promotion prospects for this grade is to senior enrolled nurse. For the purpose of this study both grades will be treated as one and referred to as "enrolled nurse".

FIGURE 1

NURSING STRUCTURE IN SCOTLAND

| Sphere of Authority | Designation | |
|------------------------------------|------------------------------|--|
| Health Board | | |
| Area (15 in Scotland) | Chief area nursing officer | |
| District | District nursing officer | |
| Division (e.g. Hospital) | Divisional nursing officer | |
| Area (e.g. within a Hospital) | Senior nursing officer | |
| Unit (e.g. within a Hospital area) | Nursing officer | |
| Ward | | |
| | Ward Staff (Clinical grades) | Charge nurse Staff nurse Enrolled nurse Student nurse Pupil nurse Nursing assistant |

Footnote In this study the term "nurse" will relate to the six ward based staff grades who deliver nursing care.

5. Staff nurse (Grade 5)

The staff nurse has trained for three years as a student nurse (see 3 above). She is potentially eligible for promotion to any part of the nursing staff structure.

6. Charge nurse (Grade 6)

The charge nurse has been promoted from staff nurse grade and has previously undergone a three year training as a student nurse (see 3 above). She is potentially eligible for promotion to any part of the nursing staff structure. The title "charge nurse" is interchangeable with "ward sister".

In two of the hospitals visited in connection with this study the grade of deputy charge nurse existed, these nurses would deputise for the charge nurse in her absence. For the purpose of this study the charge nurse and deputy charge nurse grades will be combined and referred to as "charge nurse".

The Department of Health and Social Security (1972) has made a number of recommendations which, if implemented, will result in a change in this existing nursing staff structure, and in the system of nurse training. In view of the provisions of this Act relating as they do to the role and training of the nurse, a brief critique of those aspects of the report which relate to this study will follow.

The Committee which produced the report were appointed in 1970 by the Secretary of State for Social Services under the chairmanship of Professor Asa Briggs and had the following terms of reference;

"To review the role of the nurse and the midwife in the hospital and the community and the education and training required for that role, so that the best use is made of available manpower to meet present needs and the needs of an integrated health service." p v

The Committee endorsed the statement made to them by the General Nursing Council for England and Wales that "the role of the nurse must always be closely related to the needs of the patients" para 13. This notion is repeated elsewhere in the Report, for

example; "it is not the place of treatment that should determine the nurse's contribution, but the needs of the patient" para 32. However both the role of the nurse, and the needs of patients, are referred to and discussed only in general terms in the Report, there being little evidence of the Report initiating, or taking account of any previous systematic examination of the role of the nurse or of patients' needs. Indeed, para 183 which describes the factors which should be taken into account by agencies responsible for nursing education makes no mention of patients' needs. The role of the nurse is also referred to in general terms, with no reference to systematic study of that role. The following reference to nursing, and its objectives, is typical of the general way in which the committee describe the subject;

"Professional nursing has as its objectives continuity and co-ordination of care in the interests of the comfort, recovery and integrity of the person being cared for." para 41

The Committee's decision not to undertake a systematic study of what the role of the nurse is, or of what patients' nursing needs are, may reflect its belief that these questions were already answered. However, the Committee make virtually no specific reference to these questions or their answers in the Report. The very considerable research which was undertaken by the Committee's research team, or commissioned by them, relates almost exclusively to nurses, features of nurses, or to opinions held by nurses. TABLE 44 in the Report, one of the few relating to nursing practice, describes the movement of non nursing staff into and out of a ward during a typical day.

A major recommendation of the Committee was that;

"..... the dual system of entry into the nursing profession should disappear and there should be no distinction at the point of entry, as there is at present, between student nurses hoping to proceed to registration and pupil nurses hoping to become enrolled nurses." para 47

Neither the decision to change the present dual method of entry to nursing, or the alternative admission and training system (described below) are supported by evidence indicating their necessity. The

following opinions, however, attempt to justify the proposed change;

"Although enrolment and registration are distinct qualifications, leading to very different career prospects within the profession, the actual level of work assigned to some enrolled nurses is often very similar to that assigned to some registered nurses in the staff nurse grade." para 188

and

"We have abandoned the fundamental distinctions between student and pupil nurse and registered and enrolled nurse which we believe to be harmful to the future of the profession." para 539

Despite this statement of belief, the report offers no evidence to support the notion that the proposed system will be less "harmful" than the present system, or that it will solve the problem of nurses with differing educational backgrounds doing the same work. Indeed, it might be argued that the proposed system, containing as it does more than two levels of education, might increase, rather than decrease, the problems it was intended to solve. The proposed educational structure to replace the present dual entry system is summarised below:

"b) Education

16. There should be one basic course of eighteen months for all entrants which would lead to the award of a statutory qualification, the Certificate in Nursing Practice
19. A further eighteen-month course open only to those holding the Certificate in Nursing Practice, should be provided. It should lead to a second statutory qualification, Registration. The new Register, unlike the present Register, should not have separate parts p 213
20. For the more able students, courses leading to Registration could include, or be followed by courses leading to the award of a Higher Certificate (non-statutory) in a particular branch of nursing or midwifery." p 213

In addition to the above formal training arrangements for "professional" nurses, the Committee recommend the continuation of the nursing assistant grade (aide) and suggest improvements in the training given to them.

The Committee acknowledge the gap which exists between classroom and ward, in terms of what the nurse is taught. They express it thus;

"..... there is often a wide gap between classroom and ward. Few ward sisters or charge nurses have had any preparation for teaching, and many of them object that classroom teaching is not "realistic" because 'things are not done in the same way as in the ward'." para 226

The Report recommends little which will reduce the gap between classroom and ward despite their hope that future patterns of learning must aim at bringing teaching and clinical staff closer together.

A number of questions raised by the Report of the Department of Health and Social Security (1972), and which form an integral part of this study, were either not answered in that Report, or given answers which were based largely on opinion. That it will have a considerable impact on nurse education in this country is increasingly certain in view of the report, in the form of the Nurses, Midwives and Health Visitors Act, recently taking one step nearer implementation (Nursing Times, 1980).

Having discussed nurses and nurse education in general terms, the next chapter will focus on the psychiatric nurse and the literature relating to their role.

THE ROLE OF THE PSYCHIATRIC NURSE; A REVIEW OF THE LITERATURE

Literature relating to the role of the psychiatric nurse may take a number of overlapping forms, prescriptive statement, descriptive statements and statements expressing patients' evaluation of the psychiatric nurses' role. This review will include literature of all three types, and, while not exhaustive, is intended to reflect the whole literature relating to the role of the psychiatric nurse.

1. Prescriptive Literature

In recent years nurses and others have created a rich literature relating to what the role of the psychiatric nurse should be. It is diverse and, while expressing a number of personal opinions of what nurses should do, rarely reflects a systematic examination of what the role of the psychiatric nurse is. These role prescriptions include;

(a) The nurse as the doctors assistant

Early references to the role of the psychiatric nurse saw her as being supportive to, and an extension of, medical staff. For example Connolly (1856) wrote;

"..... all his (the physician's) plans, all his care, all his personal labour, must be counteracted, if he has attendants (nurses) who will not observe his rules, when he is not in the ward, as consciously as when he is present." p 37

Varga (1974) recounted how her own nurse training had emphasised her role as being supportive to medical staff whose orders had to be obeyed unquestioningly. More recently writers such as Johnson and Martin (1958), in making a sociological comment on the role of the nurse, suggested that being "expressive" might be the specialised function of the nurse. They describe it as follows;

"We call actions which are directly related to moving the system toward its goal instrumental, and actions which are related to maintaining motivational equilibrium in the

individuals composing the group expressive." p 373 /
More recently Colledge (1973) expressed an almost identical view. Seventeen years earlier Belknap (1956) placed nurses in the role of "mediators" between patients and doctors, preventing the doctor being "swamped" by the large number of patients who invariably want to see him.

Recently the writer met with nurses at three Scottish psychiatric hospitals to discuss his method of implementing a systematic approach to nursing care commonly referred to as "the nursing process", (see Cormack, 1980). In each hospital small numbers of trained nurses, including recently trained staff, mirrored the view of the role of the psychiatric nurse being supportive to that of the doctor. One staff nurse said;

"I can see how it is possible to identify patients' specific non-physical problems, disorientation for example.

However, our role does not involve influencing these problems, that is the job of the psychiatrist."

On being asked how the psychiatrist would influence the above problem, and others such as trust, anxiety and hostility the staff nurse replied;

"The psychiatrist prescribes medications, that is how the problems are treated. The nurse assists in the treatment by giving the medications, feeding patients and making sure they are safe and so on."

The view of Connolly (1856) still exists in the minds of some contemporary psychiatric nurses, despite the large and increasing volume of literature which suggests that nurses have a personal therapeutic contribution to make in addition to that part of their role which is supportive to medical and other staff.

More than two decades ago increasing attention began to be paid to the effect of the environment, and the people in it, on the hospitalised mentally ill. The following observation by McGhie (1957), in a discussion of the role of the psychiatric nurse expressed it as follows;

"..... psychiatrists, while not doubting the efficacy of these (medical) treatments to many psychiatric conditions, have referred to the difficulty of differentiating between the

therapeutic value of the treatment itself and the interpersonal influences which are an integral part of any treatment situation." p xiii

Freeman *et al.* (1958) also commented on the influence of the people in the environment of the mentally ill, suggesting that they were the most important factor in it, a view reflected by Henderson and Gillespie (1964) who wrote;

"The nursing staff, more constantly with the patients and participating with them in many small activities and purposes, have commonly an even more important and potentially effective therapeutic role than the doctor." p 285

(b) Multidimensional role

In making a more specific comment on the role of the psychiatric nurse, some writers have expressed the role of the psychiatric nurse as taking one or more of a number of forms. For example the World Health Organisation (1957) prescribed a multidimensional role which they described as requiring technical, interpersonal and social skills on the part of the nurse. Sabshin (1957) also prescribed a multidimensional role, arguing that the time was not then ripe for emphasising one role for the psychiatric nurse. In discussing "The Nurse's Many Roles" James (1972) described the nurse as being a clinician, social worker, educator, administrator, innovator, clerk and domestic help. The roles prescribed for the psychiatric nurse by Todd (1970) and Trick and Obcarskas (1968) were also of a multidimensional type.

In contrast to those who prescribe a multidimensional role, other writers have prescribed a role which is both therapeutic and uses a specific non-medical ideological approach. The three commonly used expressions of psychiatric ideology appearing in psychiatric nursing in the past twenty five years have been the sociotherapeutic, psychotherapeutic and behavioural ideologies.

(c) Sociotherapeutic role

The sociotherapeutic approach, and the central role of the nurse in its application, was prescribed by Morton and Tibits (1970). The "therapeutic community", a frequently used means of implementing the sociotherapeutic method of treatment was described by Wax (1962)

as having the following characteristics;

- "1. Emphasis is placed on the current social behaviour of the patient in interaction with the social processes of the institution.
2. The traditional confidential one-to-one patient-therapist relationship is largely supplanted by a larger complex and highly visible network of relationships with patients and staff.
3. The therapeutic community places a very high value on communication of feelings and information.
4. Patient government and community therapy activities create a formal organisation for patients.
5. In the therapeutic community most treatment takes place in a group context." p 659 - 660

Cumming and Cumming (1962) saw the nurse as being the "key-stone" of the therapeutic community, the major task of which was to exploit the central role of the nurse. Altschul (1963) also placed the nurse in a socio-therapeutic role when she wrote;

"The nurses' special role is to create a wholesome ward atmosphere, and to influence routine and surroundings in the patients' interests." p 123

More recently Campbell (1979) discussed the problems encountered by nursing staff operating within a therapeutic community context. He advocated that, if nurses were to develop a socio-therapeutic role, training needed to be "formal and academic as well as experiential".

(d) Psychotherapeutic role

The psychotherapeutic role of the nurse has featured prominently in the prescriptive literature in recent years. For example, Peplau (1962) was in no doubt that the emphasis in psychiatric nursing was on the "counselling or psychotherapeutic sub-role". An earlier prescription by Kalkman (1958) was uncompromising in the recognition of nurse-patient interaction having a psychotherapeutic function, a view which has been echoed by many. Kalkman (1958)

wrote;

"Psychiatric nursing is primarily concerned with interpersonal interactions and only secondarily concerned with nursing procedures, medications and treatment A nurse-patient interaction can be defined as a single encounter or interaction consciously engaged in by a nurse and a particular patient in a particular setting for the purpose of facilitating the patients' recovery A nurse-patient interaction is goal directed." p 219

A number of British writers, and organisations, have advocated a psychotherapeutic role for the psychiatric nurse in this country, examples include the General Nursing Council for Scotland (1962) and the Royal College of Nursing (1970).

(e) Behavioural role

The behavioural approach to nursing has been given increasing attention in recent years by a number of writers. For example, Marks *et al.* (1973) described how five nurse therapists treated phobic patients and achieved a success rate equal to that of psychiatrists and psychologists using similar treatments in a comparable psychiatric population. Peck (1973) argued that nurses were already acting as agents of behavioural change, but that;

"The task before us is to extend this role, and train nurses to carry it out more efficiently." p 139

Literature relating to a behavioural type role for nurses is often unique in that it is both prescriptive and descriptive. For example, Barker (1976) described how the application of behavioural techniques reduced self stimulating behaviour in four profoundly retarded patients. Baker (1974), while suggesting that operant conditioning offered an approach to each problem for all types of patients, commented on the need for traditional forms of custodial-type care in addition to behavioural approaches. Post-registration courses on the use of behavioural techniques continue to develop but, according to Barker (1980a) produce staff who are impotent on return to their clinical areas unless the organisational situation to which the student returns is supportive to the behavioural ideology.

The sociotherapeutic, psychotherapeutic and behavioural roles outlined above have collectively been given increasing attention by those who seek to describe a role for the psychiatric nurse which is relatively independent of other staff groups. In reality all three role types may overlap, although they tend to be given separate discussion in the literature.

The sociotherapeutic role and treatment format relies heavily on the use of social pressures and events to influence the patient and his behaviour. Nurses, having a close 24 hour contact with hospitalised patients, are clearly in a favourable position to use the social setting of hospitalisation to influence the patient, should they wish to do so.

The psychotherapeutic role depends more on a one-to-one nurse patient contact on a regular, planned and purposeful basis. The personal skills and experiences of the nurse are used as catalysts to facilitate the development of insight and self-help on the part of the patient. The hospitalised patient, exposed as he is to constant contact and interaction with potential nurse psychotherapists has a large variety of therapists available for his benefit should nurses wish to fill that role.

The behavioural role relies on continuity of care over time and between those who are involved in that care, nurses for example. A variety of approaches to treatment are labelled "behavioural", and include the use of operant conditioning techniques. Here, pathological behaviour is identified and might be reduced or extinguished by means of reinforcing the patient for other behaviour during the periods when the pathological behaviour is absent. The behavioural approach demands consistency between staff and is ideally suited to the functioning of nurses caring for the hospitalised patient, should they wish to do so.

An important feature of the three roles summarised above is that the nurse can fill them in collaboration with, or independently of, other staff groups. All three roles are similar in that they utilise the personal therapeutic skills and contribution of the psychiatric nurse. This personal, direct and therapeutic contribution to patient care is to be contrasted with the "nurse as

the doctor's assistant" in which she was supportive to his provision of primary forms of treatment, medications for example.

(f) Administrative role

Not all writers have emphasised the clinical role, relating to direct patient care, for the psychiatric nurse. Some writers, for example Corwin (1961a) commented on the incompatibility of the clinical ideals taught in the schools of nursing, and the bureaucratic reality of the hospital. The same writer (Corwin, 1961b) claimed that nurses were better rewarded for administrative excellence than for clinical skill. A number of years earlier Stanton and Schwartz (1954) identified the role of the trained nurse as being more concerned with the co-ordination of care, while untrained staff, such as nursing assistants, provided most of the direct nurse-patient contact. More recently Field and Pierce-Jones (1967) described nursing as being at the cross-roads of having to accept a primarily co-ordinating function or a patient-centred clinical role. The Royal College of Nursing (1971), recognising the need for greater clinical, as opposed to administrative, career opportunities for nurses, suggested an extended promotional structure for nurse clinicians. Cormack and Fraser (1975) were also critical of the increasing administrative orientation of the nurse and proposed the incorporation of a clinical component into all nursing administrative posts, or the creation of a clinical career structure to parallel the existing nursing administration structure. A similar suggestion was made by Carr (1980) speaking at a recent Royal College of Nursing Conference.

(g) Psychiatry under review

A recent series of papers published in the Nursing Times attempted to "provide a framework to guide the nurse into the state of psychiatry in the eighties". The series, written by experienced and well known nurses, related primarily to the nursing care of the mentally ill. Because of the comprehensiveness of the collection of papers, they will be reviewed here as part of the prescriptive literature.

Altschul (1980a), in the opening article of the series, suggested that nurses should examine the various perspectives on the subject of mental disorder, and develop skills in psychiatric nursing based on

whichever approach they regarded as helpful to a specific situation. The alternatives open to the nurse using this eclectic approach were, according to Altschul (1980a) contained in the medical, social or psychological models of care, suggesting that no one model is always appropriate.

Hessler (1980) in a paper entitled "Roles, status and relationships in psychiatric nursing" suggested that the nurse caring for the mentally disordered can perform a variety of roles including those of parent, friend, counsellor, technical nurse and psychotherapist. Clearly implied here is the notion of the nurse as providing a personal therapeutic contribution to patient care.

Altschul (1980b) extended the discussion of "role", initiated by Hessler (1980), to include the blurring of staff-patient roles in the therapeutic community form of treatment. In relation to the process by which the patient releases, then regains, responsibility for himself. Altschul describes how the role of the nurse;

"..... may take on a rapidly changing kaleidoscope of roles as friend, guide, mentor, boss, judge and jury." p 555

Harris (1980), in the fourth paper in the series, focussed on the contribution of non-professionals in psychiatric care and included such groups as the Samaritans and volunteer workers. The final paragraph of that paper makes a pointed statement relating to psychiatric nurses:

"..... we (psychiatric nurses) are not sufficiently aware of the power we possess to give a service of high repute. We need not be destined to a lowly position, and indeed we do our patients little service by allowing our work to be underestimated." p 603

Altschul (1980c) directed her third paper to the maintenance of patient-nurse interaction, suggesting that the objective of interaction is to help the patient to understand himself better. The writer, having given a number of practical hints relating to nurse-patient interaction, concludes by describing how the content and purpose of the interaction will be influenced by the prevailing psychiatric nursing ideology.

Schröck (1980a), having discussed the problems encountered in planning patient care, proposes a further role as co-ordinator for the psychiatric nurse. The danger of duplicating patient care plans, with the advent of the multidisciplinary approach to psychiatric care, may be lessened, according to Schröck, if nurses play a key role in the co-ordination of patient care.

Recording a nursing history, an integral part of the nursing process, is the subject of the paper by Smith (1980). A data sheet is presented, to be used when recording a patient's nursing history. The items, reflecting a psychotherapeutic and socio-therapeutic approach, include the following general topics;

- (a) History of past illness
- (b) Self (including perception of illness)
- (c) Daily living activities
- (d) Cognitive features (including orientation)
- (e) Patient's perception of affective emotional behaviour
- (f) Patients social patterns and
- (g) Patient's perception of future goals

Data obtained via the nursing history is then used to formulate a nursing care plan.

Altschul (1980d) discussed the role of the nurse in the context of the team approach to psychiatric care emphasising the importance of nominating one nurse to be responsible for the record keeping for an individual patient. The allocation of a particular nurse to each patient, in order that the patient can identify "his" nurse, is seen as an ideal. Altschul (1980d) gives clear recognition to the fact that the role of the nurse depends on the prevailing treatment ideology, ranging from the nurse carrying out medical orders, to functioning with autonomy and initiative in a socio-therapeutic setting.

Simpson (1980a) focussed attention on the nature of confidentiality in psychiatric nursing, rather than on the role of the psychiatric nurse. Implied in the paper is a sociotherapeutic role for the nurse, in the discussion of confidentiality relating to the nurses' participation in group psychotherapy.

Schröck (1980b) added a further dimension to the role of the psychiatric nurse suggesting that;

"..... the nurse's prime moral obligation lies in standing up for the patient's rights" p 887

and

"..... the nurse must be in the unique position of being the patient's advocate rather than being solely the interpreter and facilitator of medical orders." p 887

Barker (1980b) in an exploration of ethics, nursing and behaviour modification discussed a number of ethical issues involved in that form of treatment. That writer goes on to suggest that nurses are becoming increasingly aware of the need to define their area of responsibility, adding that the success of patient treatment may result from nursing care and attention, rather than from any single medical process. The writer describes the training given to most nurses involved in behaviour modification programmes as being "little more than basic instruction in the mechanics of behaviour modification."

Simpson (1980b) was critical of the physical care element in the training of the psychiatric nurse and suggested that it contributed little to the skills which they require to apply current sociological therapies. That writer expressed concern about the future of psychiatric nursing as a specialty and considered it "crucial" that psychiatric nurses consider their role and their preparation for that role. The increasing use of social methods of treatment, and the relative decline in the use of physical methods, point to the need for a critical review of the nature of psychiatric nursing and psychiatric nurse training.

There can be little doubt that the role of the nurse, as prescribed in contemporary literature, is very different from that of two decades ago. The new role prescriptions, which supercede those of the nurse as a custodian and follower of "doctor's orders" have undoubtedly confused, rather than clarified, the psychiatric nurses' role. In examining the prescriptive literature, it is difficult to identify a unifying thread, consensus of opinion or areas of care which are exclusive to that group of people called "nurses".

It may be that those who advocate sociotherapeutic, psychotherapeutic or behavioural roles for the psychiatric nurse are doing no more than substituting these models, which are largely dependent on the ideology practised by the patient's doctor, for the earlier medical and custodial model of care. In short, it may be inappropriate to prescribe roles for nurses as autonomous therapeutic practitioners, while they are neither trained to fill such a role nor willing to deviate from their doctor dominated subservient role.

Much of the prescriptive literature is rather vague about the criteria for deciding when nursing intervention is necessary. For example, relatively little is said of patients' specific nursing needs, much more being said about the means of meeting those needs. Despite the abundance of literature prescribing a specific therapeutic role for the nurse, many nurses continue to function as a custodian and servant of the doctor.

2. Descriptive Literature

Although British psychiatric nursing has been the subject of very little systematic study (Towell 1975), the small number of British research based studies are beginning to provide a description of the role of the psychiatric nurse.

Earlier studies of the work of the psychiatric nurse, for example, those by Oppenheim and Eeman (1955) and Goddard (1955) used an exclusively quantitative approach in which the time nurses spent on various activities was examined. The purposes for which the reports were undertaken clearly influenced the form of the data collected, for example, Oppenheim and Eeman (1955) wrote;

"The main purpose of the investigation was to determine how much time is spent by mental nurses in hospital carrying out the various duties for which they are trained and employed, and particularly how much time is spent on domestic duties." p 8

Although not specifically interesting themselves in the therapeutic role of psychiatric nurses, these writers did make a number of interpretations which gave some insight into the (then) role of the

nurse. They implied, for example, that the volume of nurse-patient communications which existed depended less on the time available to talk with patients than on the willingness of the nurse to do so. A similar conclusion was arrived at by Goddard (1955) who, having analysed the amount of time nurses spend on their range of duties, suggested that nurses should be taught to employ their "free" time in duties of a more therapeutic nature.

John (1961) did not confine her data collection to the use of quantitative measures, in the belief that;

"The anecdotal rather than the "time and motion" approach to the main theme has been employed deliberately in the belief that it is a more useful vehicle for conveying what has been described elsewhere as "the spirit of the work"."

p 3

That study concluded that "patients were receiving inadequate nursing care both of a psychological and physical nature". However, the evidence on which that conclusion was based is unclear and the selectivity applied to data collection open to criticism.

The report of the Ministry of Health (1968) attempted to examine and describe the (then) and future role of the psychiatric nurse. It was a product of committee meetings, visits to psychiatric hospitals and the views of a number of people involved with, or showing an interest in psychiatric nursing. In large part the description of the role of the psychiatric nurse consisted of personal opinion, rather than systematic study. For example it was stated, without apparent supporting evidence that;

"..... psychiatric nurses spend much time listening to and counselling patients, that some have an active psychotherapeutic role and all carry out supportive psychotherapy to some degree." p 41

Later that year the Nursing Mirror (1968) said of the report

"As a truthful report of the present situation in many of our psychiatric hospitals, it is a travesty." p 7

suggesting that it was a prescription for the future rather than a description of the present role of the psychiatric nurse.

The purpose of the work by Altschul (1972) was to study the nature of one-to-one contacts between nurses and patients and the factors which appeared to influence the dyadic interaction between the nurse and patient. Altschul concluded that it was impossible to obtain any picture of the treatment ideologies which prevailed amongst nurses or of any theoretical basis upon which nurses act in their one-to-one interactions with patients. Four major questions were raised by the study and recommended by Altschul as being possible avenues for further research;

- 1) "What is the theoretical basis on which sound nursing practice is to be based?" p 196
- 2) "What training do nurses receive now, in the formation of relationships or in the participation in interactions?" p 196
- 3) "What forms of communications between the members of the psychiatric team would help nurses to conceptualize what they are doing" p 196 - 197
- 4) "What criteria can be used to evaluate the effect of nursing care?" p 197

Although Altschul examined one relatively narrow aspect of the work of the psychiatric nurse, the resulting questions presented above have profound implications for all areas of psychiatric nursing practice.

Towell (1975) in his sociological study of modern psychiatric nursing practice collected field data in one psychiatric hospital seeking to;

"..... discover how nurses understand the behaviour of patients in these various ward settings and with what consequences for their actions in relation to patients." p 13

The role components of the subjects of that study, nursing assistants, pupil nurses and student nurses, were identified in relation to three different types of wards. In the admission wards, containing short stay acutely ill patients, nurses played a key linking role between the patients and most aspects of hospital arrangements. Nurses were concerned with acting as adjuncts to the medical staff in somatic treatment, with social interaction forming a significant,

although discretionary, component of their work. On the geriatric wards the nurses' dominant concern related to the administration of the basic physical necessities for the old people housed there, nurses spending little time in verbal interaction with patients. On another ward developing as a therapeutic community, physical treatment was de-emphasised and nurses were mainly involved in interaction with patients, providing them with an opportunity to be active in "social therapy".

Towell (1975) concluded that the label "psychiatric nurse" in fact encompassed a cluster of different roles, varying quite radically according to the setting in which these were performed. He also commented that forming "personal relationships", given much emphasis in many recent role prescriptions, was a limited feature of the role of the psychiatric nurse.

The gulf between the role which is prescribed for the psychiatric nurse and their actual role was also reported in a study by Cormack (1975) whose comparison of prescribed and described (observed) role was a major feature of the work. Cormack (1975) confined himself to studying the work of the charge nurse in acute admission wards of psychiatric hospitals.

Thus, the prescriptive and descriptive literature relating to the role of the psychiatric nurse do not coincide, nurses do not appear to be doing what the literature suggests they ought to be doing. The extent to which this difference is real, or an artifact of the type of (largely descriptive) research procedures used is difficult to estimate. Indeed, it is arguable that the limited number of studies of the role of the psychiatric nurse are insufficient to make a definite statement about the actual role of the psychiatric nurse. Furthermore, much of the existing research work has relied on researcher observation, interpretation and description of the psychiatric nurses' role, less reliance being placed on a description made by the nurse herself.

The present study will seek to fill the existing gap in knowledge relating to how providers of nursing care (nurses) and recipients of nursing care (patients), perceive the role of the psychiatric nurse. These two groups will describe the role of the nurse in terms of nursing activities which have actually occurred, rather

than in terms of what they think the role of the nurse is.

3) The role of the psychiatric nurse; patients' views

American and British nurses are paying increasing attention to what their patients can tell them about their role. While some writers, including Marram (1976) hold the view that such data obtained from patients may not be reliable and valid, the opposite view is held by the majority of others. The findings of a small number of writers who have used the opinions of psychiatric patients are presented below and serve to illustrate how the views of patients can be used to examine the role and contribution of the psychiatric nurse.

Although the work of Cartwright (1964) was not concerned with the mentally ill, it does demonstrate the value of patients evaluating the care which they receive. That writer suggested that the successful application of medical knowledge depends on what patients think and feel about doctors, nurses and hospitals and that the mere perception of nurses in a positive light may be therapeutic in that it is a prerequisite for the success of much of the care/cure process.

Ferguson and Carney (1970) studied patients' assessment of the relative value of patient-social worker, patient-nurse and patient-doctor relationships. The setting for the study was a psychiatric day hospital attended by both acutely and chronically ill patients suffering from neurotic and psychotic type illnesses. The writers constructed a set of questions designed to determine the extent to which patients' viewed their relationships with staff as valuable, and to identify the staff group with which relationships were most/least valuable. Ferguson and Carney (1970) concluded that;

"In the present study the most striking finding is the high nurse evaluation. This merely confirms the findings of many other workers and is now commonplace. The doctor's standing is apparently lower, and the social worker's lowest of all What are the possible reasons for the high evaluation of the nurse? First of all, in terms of time the patient is interacting with the nurse for many hours longer than any other staff member; possibly, therefore a

feeling of greater intimacy and reduced social distance develops." p 402

Ballinger (1971) confirmed the findings of Ferguson and Carney (1970) regarding patients' expression of the positive value of talking to nurses, finding that patients reported on nurses being helpful more frequently than they reported on doctors or other patients.

Raphael and Peers (1972) asked psychiatric patients to comment on various aspects of their hospital. Data were collected from 2148 patients in six large psychiatric hospitals; only 2% of the respondents gave irrational answers to the questionnaire. The writers reported that the majority of the comments made by patients expressed sensible appreciations or constructive criticisms. Predictably, not all patients' comments were favourable in relation to nursing care, 12% being critical, the writers noting that most patients were happy with nursing care stating, for example, that; "They give me respect" and "see patients as adults on equal terms, not as pathological cases or children" and "I feel wanted".

While only part of that work related to patients' satisfaction with nursing care, two of its features are of extreme importance for psychiatric nurses. First, a significant majority of patients were satisfied with nursing care, and their descriptions of the manner in which nurses help them can be of much assistance to nurses in understanding their role. Second, the document is convincing evidence of the ability of patients to comment constructively and meaningfully on what psychiatric nurses deliver to them.

Altschul (1972) also collected data from patients, asking them about the kind of help they got from nurses, the result indicating both the value of patients comments and the general positive nature of patients' perception of nurses. Altschul (1972) reported that the attributes which patients most frequently mentioned in relation to nurses were;

"kind, cheerful, courteous, helpful, obliging, friendly, considerate, sympathetic, efficient, nice" p 171

Altschul concluded from her interviews with patients that they were much more certain than were nurses of the value of nurse-patient

interactions. Another important finding, relating to the role of the nurse, was that patients placed considerable value on the availability of nurses, just knowing that they were there if the patient needed them.

Westland (1973) interviewed hospitalised patients in acute admission wards just prior to their discharge. She concluded that the use of a structured interview technique to determine patients' attitudes to hospitalisation was valid. In general terms patients found that "talking to nurses" to be of value as is implied in the following comment made by Westland (1973)

"..... although no formal facilities existed for group therapy, it was clear that patients thought they derived much benefit from participating in ad hoc discussions during which they were able to talk freely about themselves and their illness, with or without the nursing staff, who occasionally participated from inclination rather than duty." p 27

Cormack (1975) also reported favourably on the ability of patients in acute admission wards of psychiatric hospitals to comment on the nature of the care provided by nursing staff. Those patients who did perceive nurses as having a positive therapeutic role were asked, in a semi-structured interview, to describe the manner in which nurses were helpful. The areas which produced the largest number of comments were;

(a) The personal qualities of the nurse (they are friendly, accepting, non-judgemental, discreet, kind, considerate and sympathetic).

(b) The confidence which nurses inspire ("nurses tell me I will get better", "They give me hope").

(c) The atmosphere created by nurses ("This is a homely place", "There isn't a hospital atmosphere here").

(d) The availability of the nurses (nurses help "by just being there").

(e) The ability of the nurse to empathise ("they understand how you are feeling").

Trauer and Moss (1980) collected data from psychiatric patients relating to their opinion of nursing staff ceasing to wear uniform. A number of other writers have used patients as sources of data when studying psychiatric nursing or features of psychiatric nurses (See Abdellah and Levine (1957), Klett *et al.* (1963), Almond *et al.* (1969), Handler and Perlman (1973), Leonard (1975), Swearingen and Thompson (1978)).

It can be concluded that the consumers of the services of the psychiatric nurse, psychiatric patients, have a part to play in assisting nurses understand their role. In general terms patients view the nurse as being positive and therapeutic, they feel that we can help and that we want to help. It seems that, unwittingly or otherwise, psychiatric nurses have the ability to convey their warmth, understanding, and acceptance to their patients. These skills, crucial to the formation of a therapeutic relationship (Rogers 1965) gives psychiatric nurses a unique opportunity to play a more specific, active and therapeutic part in patient care if they wish to do so.

Despite the now commonplace contribution which patients make to discussion of the role of the nurse, the validity of such a contribution may be questioned from a number of viewpoints. First, it can be argued that patients may have a vested interest in telling nurses what they want to hear viz. that their contribution is positive and valued. Second, that patients do not have the knowledge or professional expertise on which to base an opinion about the nature of the nursing care which they receive. Finally, it may be argued that psychiatric patients, by virtue of the nature of their illness are not capable of making such a contribution.

The view taken in this study is that patients have a contribution to make to the discussion of the role of the psychiatric nurse, providing that that contribution is one of a number which constitute a comprehensive view of the role of the psychiatric nurse.

Conclusion

The literature provides a wide range of role prescriptions and descriptions relating to the psychiatric nurse. Invariably the prescriptions do not coincide with the descriptions, the former

being largely based on individual opinion, the latter being largely based on observation and personal interpretation of the psychiatric nurses' role.

The prescriptive literature places the nurse in a specific, formal therapeutic role in which she makes a personal contribution to patient care which is autonomous and as potent as the care provided by other groups, including medical and other staff. The writers of such literature present convincing arguments to suggest that nurses can, with a lesser or greater amount of additional training, fill these therapeutic roles.

Much of the prescriptive literature focuses on how to achieve change, giving relatively less attention to what requires to be changed, or how to evaluate the outcome of nursing care. A notable exception to the lack of specific problem identification and outcome evaluation is the literature relating to the use of behavioural techniques. Prescriptive literature with a behavioural basis tends to follow a sequence which includes;

- (a) identification of patients' specific nursing needs;
- (b) stating specific patient/nursing goals;
- (c) devising a nursing care plan, based on a behavioural model designed to meet patients' specific needs;
- (d) implementing the nursing care plan which is written and shared with all those who are contributing to the patient's care;
- (e) evaluating, using pre-determined criteria, the outcome of the nursing care plan.

The descriptive literature fails to identify actual nursing practice as being the same as that prescribed in much of the contemporary nursing literature. It is clear that psychiatric nurses are still largely concerned with supporting the treatment prescribed by medical staff and assisting in the delivery and monitoring of that (medical) treatment. Where nurses are filling a formal therapeutic role, there is some evidence to suggest that it results from a wider multidisciplinary shift toward one or other of the therapeutic ideologies, rather than a unilateral decision on the part of nurses to fill a personal therapeutic role.

Non-practising nurses, researchers and academics are the principal contributors to the expansion of nursing research and prescriptive literature in the United Kingdom, relatively little data existing relating to how nurse practitioners view their role and work. It is proposed in this study that an examination of the role of the practicing psychiatric nurse from her viewpoint is both desirable and seriously lacking in much of the previous examinations of the psychiatric nurses' role.

A second gap in the existing literature relates to the role differences which may or may not exist between nurse grades. At present there are six staff grades working with hospitalised psychiatric patients, the experience and/or training of each of these nurse grades being different. Much of the existing literature says little about the role differences which exist between the various nurse grades.

The similarities between the role of the nurse working in the three major specialties within psychiatric nursing has also failed to receive specific examination, particularly in the prescriptive literature. For example the following question may be asked and has implications for the training and assessment of nurses;

"Is the role of the nurse caring for the short term acutely ill patient the same as the role of the nurse caring for the long term chronically ill patient?"

Specialty differences, largely ignored by much of the prescriptive literature, was emphasised by Towell (1975). The relative dearth of systematic examination of specialty differences and similarities has prompted an examination of that topic in this study. Clearly, if the roles are different then training and assessment should take account of this.

A further potential role difference which has been given relatively little attention is between nurses working on day shift and on night shift, again, differences will have implications for training and assessment and are rarely mentioned in the prescriptive or descriptive literature.

The effectiveness of nursing care is a further area which has not been given full consideration in the literature. Having read

the literature, the reader is frequently left wondering how she will know when her performance has been effective or ineffective. While this study will not seek to produce external and objective criteria by which to measure the effectiveness of nursing care, it will seek to identify a consensus opinion, expressed by staff and patients of what constitutes "effective" nursing care.

Further related questions which are left unanswered by the literature relating to the role of the psychiatric nurse are concerned with the assessment of patients' nursing needs, the educational needs of nurses, and the means of assessing nurses' clinical performance.

CHAPTER 4

OBJECTIVES OF THE STUDY

The major objective of this study is to "describe the role/s of ward based psychiatric nurses in a sample of eleven Scottish psychiatric hospitals".

The data used to achieve the above objective, critical incidents, is analysed to determine the extent to which the role of the nurse differs between;

- (a) Night shift and day shift.
- (b) The major psychiatric nursing specialties;
 - (i) Acute admission
 - (ii) Psychogeriatric
 - (iii) Long-stay ambulant
- (c) Ward based nurse grades;
 - (i) Nursing assistant
 - (ii) Pupil nurse
 - (iii) Student nurse
 - (iv) Enrolled nurse
 - (v) Staff nurse
 - (vi) Charge nurse

and to achieve a further four related aims;

- (i) To obtain an objective basis by which to assess patients' nursing needs.
- (ii) To formulate criteria by which to measure the effectiveness of the work of the psychiatric nurse.
- (iii) To provide an objective appraisal of the educational needs of the psychiatric nurse.
- (iv) To provide a basis for an objective assessment of nursing performance.

A second type of data "Documentary Data" were collected and evaluated in order to establish the educational input, job descriptions and means of assessing the six clinical nursing grades who were the subjects of this study. The documentary data took

three forms;

- (a) Job descriptions
- (b) Training syllabi
- (c) Assessment forms

THE RESEARCH METHOD

The principal objective of this study was to gather data to enable a description of the role of the psychiatric nurse to be made. The question to which an answer was sought, using methods of direct observation, was "What is the role of the psychiatric nurse?" The major form which the data collection took is known as the "CRITICAL INCIDENT TECHNIQUE", and was supplemented by a secondary form of data, "DOCUMENTARY DATA".

Critical Incident Technique

Nurses were observed by other staff, themselves and patients while working in their natural environment. The general approach to the observation and description of the activity (behaviour) of the nurse is similar to what has been described by Hutt and Hutt (1970) as "The Ethological Approach", the observation and description of naturally occurring behaviour. This study differed from the ethological approach, as described by Hutt and Hutt (1970), in that it relied on retrospective reporting of events called from memory by the respondents.

In arguing for the use of an ethological approach to the examination of contemporary psychological problems Hutt and Hutt (1970) recognise that the research method is not new, for example they refer to its use by Darwin (1872), "in studying the behaviour of men and other animals". The writers also comment on the haste with which psychology has abandoned (or neglected) this important step in understanding behaviour. They cite Tinbergen (1963) as writing;

"It has been said that, in its haste to step into the twentieth century and to become a respectable science, Psychology skipped the preliminary stage that other natural sciences had gone through, and so was soon losing touch with the natural phenomena." p 4

Clearly, it might be argued that the very recent concern with a "body of knowledge" which has developed in the nursing profession

has been less concerned with "what is" than with "what should be". Psychiatric nursing is a varied and complex activity about which far too little is known despite the existence of a small number of descriptive research studies (for example see Oppenheim (1955), Manchester Regional Hospital Board (1955), John (1961), Altschul (1972), Towell (1975) and Cormack (1975)). This study sought to continue the description of psychiatric nursing with the intention of leading to an increased understanding of the role of the psychiatric nurse. In addition to this measure of typical performance, it was intended that criteria for the measurement of effective/ineffective psychiatric nursing and role variations between shift, specialty and grade could be established from the data.

In deciding which observational method would yield the quantity and quality of data to best meet the above objectives, it was decided to use, and yet deviate from, the ethological approach described by Hutt and Hutt (1970). It was felt that an observation technique which included observation of examples of all overt nursing behaviour would be necessary, that the observers would include nurses and others involved in carrying out the nursing function, for example, patients and doctors, and that selected behaviour would be reported by them. Finally, it was decided that reports of nurse behaviour would be based on observation and description of discrete and complete elements of behaviour. While the ethological approach to the observation and measurement of behaviour demands the use of continuous observation techniques and the inclusion of all aspects of behaviour, and its context, the writer relied on rather more selective reporting. While all nursing behaviour was the subject of observation, only those elements of behaviour which were considered by the observer to be important aspects of the delivery of nursing care were included. This selective approach served a number of functions which include the following:

- (a) It hopefully eliminated the collection of data relating to those aspects of the role of the psychiatric nurse which are unrelated to, or peripheral to, the general aim of nursing activity.

- (b) the focussing of attention on those aspects of the nursing role which were felt by the observers to be central to the general aim of the nursing activity;
- (c) the identification of those elements of "nursing" which constituted either effective or ineffective nursing care;
- (d) the inclusion of observations by important non-nurse participants in the delivery of nursing care. For example, patients and medical staff were unable to observe and report on all aspects of the nursing role, however, each group observed and reported on nursing activity from a unique viewpoint;
- (e) the observation of complete behaviour, for example by a nurse who reported on an aspect of his own functioning, and the reporting of only selected aspects of the observed behaviour enabled very much larger numbers of observers/reporters to be recruited;
- (f) finally, the observation and reporting of total behaviour patterns of nurses has already been undertaken, for example see Oppenheim and Beman (1955), Manchester Regional Hospital Board (1955), John (1961), Cormack (1975) and Towell (1975). While these studies have increased general understanding of the role of the psychiatric nurse, there remains the question of what constitutes effective or ineffective psychiatric nursing care in specific situations according to the nurses themselves.

It was proposed that a description of effective and ineffective psychiatric nursing care would be obtained by using the critical incident technique described by Flanagan (1954). This technique requires that observers of specific incidents, for example nurses who observe the work of other nurses, be asked to record these as explicitly as possible and describe them in terms of examples of effective or ineffective nursing. As increasing numbers of incidents are obtained, a profile of what a nurse requires to do, and not do, in order to be described as an "effective" nurse emerges. Flanagan (1954) defined a critical incident as being;

"..... any observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act an incident must occur in a situation where the purpose or intent of the

act seems fairly clear to the observer and where its consequences are sufficiently definite to leave little doubt concerning its effects" p 327

Retrospective reporting as a means of collecting critical incidents has been widely used (See Rimon (1979) Flanagan (1954) Fivars and Gonsell (1966)). Despite the known problems relating to retrospective reporting, forgetting and subconscious editing for example, it continues to be used in relation to studies relying on critical incidents. It is argued that the use of the retrospective method of reporting, as opposed to reporting on current events, has a number of distinct advantages in this type of study.

First, this approach enables respondents to describe incidents which occurred in the recent or less recent past providing they are perceived as examples of effective or ineffective nursing. Thus, the long and short term experience which shapes contemporary nursing become available for inclusion in the population of critical incidents.

Second, some incidents may occur infrequently but may be seen as an important facet of nursing, the application of external cardiac massage in a psychiatric hospital for example.

Third, the retrospective account enables the longer term consequences of activities to be observed and included in the critical incident in a manner which would be less possible otherwise. For example, a respondent may describe the development and use of a one-to-one relationship with a patient over a period of many weeks.

Fourth, the use of retrospective reporting avoids the possibility of nursing activity being manipulated to provide more "realistic" or "plausible" outcomes.

Fifth, in relation to nursing, the strength of the critical incident technique lies in its ability to investigate nurses' perception of their role and observed events, rather than necessarily provide a completely accurate account of them. This is particularly important and relevant when considering that the response of a contemporary nurse in a given situation will be influenced by her

perception and memory of past experiences, as well as the reality of them.

Finally, however, it must be recognised that the retrospective reporting method is only one way of obtaining descriptions of nursing activity. Ideally it would need to be complemented by direct observational studies of a similar nature and by experimental studies where specific procedures or activities are singled out and their effectiveness determined.

The Use of the Critical Incident Technique in Nursing

Since the first formal description of this data-collecting technique by Flanagan (1954), it has been used by a number of workers attempting to investigate aspects of nursing practice. Prior to 1954 the method had been used to investigate the work of a number of other non-nurse groups (see Flanagan (1954) for a review of the literature).

In relation to nursing the technique has been used largely in the U.S.A., although it is being given increasing attention by researchers in the United Kingdom, for example by Sims (1976), Long (1976), Crow (1978), Cunningham (1979) and Clamp (1980). The critical incident technique was used by Clamp (1980) to "assess and study nurses' attitudes" who described critical incidents as being;

"..... snapshot views of the daily work of the nurse the advantages of this technique are that they provide a sharply focussed description in which opinions, generalisations and personal judgements are reduced to a minimum." p 1756

Flanagan (1963) used the technique to construct^a twelve item framework which could be used to evaluate the performance of student nurses. Gorham *et al.* (1959) used the technique to identify nursing behaviours which were important to patient care while Rosen and Abraham (1963) used it to develop an evaluation procedure for assessing staff nurses. Pumroy and Suttell (1956) made a rather more specialised application of the technique when they used it to identify the role of the private duty nurse in the hospital environment. Safren and Chapanis (1960) used it for yet another purpose, that of identification of behaviours which increased or decreased the incidence of medication errors. In a recent paper Rimon (1979) employed the critical incident technique to study nurses' perception of their psychological role in treating rehabilitation patients.

It can, therefore, be said that the critical incident technique has had a wide and varied application to nursing and has been given

increasing attention by British and other non-American researchers in recent years.

In 1973 the American Institute for Research published a 1200 page report of a research project which was based on the use of Flanagan's Critical Incident Technique and which sought to identify the critical behaviours of trained psychiatric nurses and aides (see Jacobs, Gamel, and Brotz (1973)). This extensive project which sought to identify the critical behaviour of American trained and untrained psychiatric nursing staff used the stratified sampling method for selecting health care facilities for inclusion in the study. The following three types of psychiatric-mental health facilities were included in the sample;

1. Psychiatric hospital
2. General hospital with a psychiatric unit
3. Comprehensive community mental health centre

Only those facilities which were judged by a panel of "knowledgeable nurses" to be "progressive" were included in the sample.

Progressiveness was defined in terms of "innovativeness", the rationale for including only progressive facilities being explained as follows;

"The philosophy and setting of a care-giving facility affect the activities which occur there. Since future needs demand a progressive approach, considerable planning went into the selection of facilities for inclusion of this study. Facilities determined to be current and innovative were invited to participate. The rationale for this biasing effect was that these facilities would be most likely to suggest future directions for mental health personnel. Thus the data sources were chiefly facilities known to be at the forefront in emphasising the preventive social-education intervention, and collaborative roles of the nursing personnel in addition to the more traditional supportive role." Vol. 1 p 6

Unfortunately, very little information is given on what the "knowledgeable nurses" regarded as being progressive as opposed to non-progressive. However, one criterion for inclusion of a facility in the "progressive" category was "willingness of the staff to participate in new activities and programmes". Despite this

criterion for "progressiveness", 27 out of 73 such facilities declined to participate due to being "unable to contribute meaningfully to the study" or because of conflicts with the researchers' schedules. Fifty facilities were selected and agreed to participate, data being collected using the method described by Flanagan (1954), a total of 8,659 incidents being reported. Jacobs *et al.* (1973) described the uses to which the collected (and analysed) data may be put, there is no reason to suppose that similar use could not be made of data collected in and applying to psychiatric nursing in this country. They wrote:

"It is our premise that the data supplied by a study of critical requirements of psychiatric nursing are the type of factual objective and relevant data that are most valid as criteria for the three-pronged front of prediction, training and evaluation. Without specific and adequate criteria, selection instruments cannot be validated, training does not have a concrete end goal and evaluation proceeds on meaningless parameters." Vol. 1 p 60

Having collected and inductively classified the 8,659 critical incidents, Jacobs *et al.* (1973) go on to comment on the difficulty of utilising the classified data to construct appropriate selection tests, performance evaluation instruments or training content. They report that users of a similar source book prepared by Larson, Nichols and Jacobs (1969) also reported that it was difficult to bridge the gap between raw data and construction of selection tests, evaluation instruments or training content.

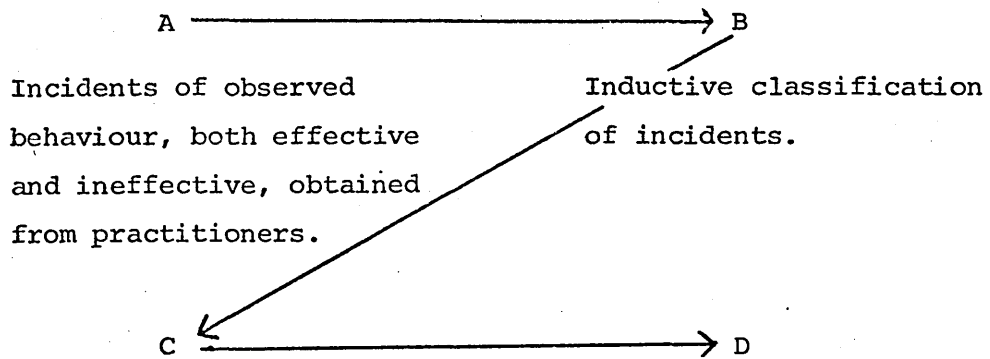
It would seem that, bearing in mind the ethological basis of the Critical Incident Technique and its application to actual rather than theoretical situations the use of the tool to develop predictors of "good" psychiatric nurses would be inappropriate. While there can be less of an argument against the ability of the tool to identify attitudes which, if they existed in a prospective nurse, would be regarded as "desirable", it can be argued that the existence of the attitudes in a nurse is no real indicator that he will exhibit specific positive behaviour in actual nursing situations. In other words, if a nurse says she will act in a certain way in a given practical nursing situation it does not mean that she will

do so in reality.

One major strength of the critical incident approach is that it usually results in a specific description of what nurses actually do, rather than in a description of what respondents think they do or of what they should do. It also avoids the questionable assumption that nurses actually respond to a given situation in the same way in which they say they would respond if faced with that situation. Bendall (1975) not only highlighted the difference between what was taught in schools of nursing and what was practiced in the wards, but also between what examined students said they would do in a given clinical situation and what they actually did when faced with that situation.

This study is designed to obtain a description of the role of the psychiatric nurse which is as comprehensive as the data collection method will allow. It is recognised that while the product of the data collection may not constitute a totally comprehensive description of the work of the psychiatric nurse, the role of the psychiatric nurse will be no less than that contained in the data.

This study will not be concerned with the development of predictors for the selection of "good" psychiatric nurses, however, it is concerned with an examination of the role of the psychiatric nurse and the related areas of training, performance evaluation and criterion measures. The following model, adapted from Jacobs *et al.* (1973), Vol. 1 p 59, demonstrates the steps to be taken in moving from collection of critical incidents to the formation of training content, performance, evaluation and criterion measures.



Rationale

(a) Description

Training

(b) Analysis

Performance
Evaluation

(c) Item Specification

Criterion Measures

In moving from B to D, Jacobs *et al.* (1973) suggest the following series of steps:

1. Designation: includes the title and list of behavioural categories. For example, "Makes ward or unit into a therapeutic community".
2. General Behaviour: a summary statement of the kinds of behaviour included in the category. For example, "..... the activities of the nurse or psychiatric attendant which serve to establish and maintain the mental health ward or unit as a therapeutic community".
3. Description of Component Behaviours: the unique behaviour in each sub-category is described. For example, "Helps patients understand and help each other".
4. Analysis: consists of inferences made regarding the skills, abilities, aptitudes, traits or attitudes which may play an important part in determining the nursing staff members competency in the category. For example,
 - (a) full acceptance and value of the nature and value of the therapeutic community approach;
 - (b) possession of basic humanistic qualities and understanding;

- (c) ability to recognise and act in situations which call for the use of peers and patient groups;
- (d) knowledge of when and how to intervene in the group's responsibilities;
- (e) skill in conducting groups;
- (f) skill in supervising and directing others;
- (g) skill in developing and maintaining therapeutic relationships with patients.

5. Item specification: recommendations are made for teaching or evaluating the traits or abilities emerging from the analysis. For example:

- (a) Training Recommendations: describes training objectives and proposes a number of possible training techniques.
- (b) Performance Evaluation: measurement of the attitudes and abilities listed in the analysis summary (includes some examples of methods of measurement).

In summary, it seemed that a profitable examination of psychiatric nursing based on an adaptation of the ethological approach (see Hutt and Hutt 1970) could be achieved using the Critical Incident Technique (see Flanagan, 1954). Data derived from such an examination were examined and used to meet the objectives of this study (see Chapter 4).

Documentary Data

The following documentary data was collected from the hospitals participating in this study;

- (a) Job descriptions
- (b) Job training syllabi
- (c) Job assessment forms

The purpose of this type of data is to provide a formal description of what the six nurse grades who form the subjects of this study are expected to do, are trained to do, and the criteria on which each grade is assessed in terms of performance.

Implications for Assessment, Clinical Practice and Education

Knowledge of the actual role of the nurse practitioner must also be of importance in relation to her preparation to fill that role. Traditionally, much of the formal training of the nurse has been based on the exposure of the learner nurse to lectures, talks and demonstrations of nursing practice. An essential feature of this training is a measurement of the learner's ability to recall and describe the information previously imparted to her; this measurement usually takes the form of written examinations.

Implied in the use of such a teaching and examination system are a number of assumptions which can no longer be regarded as true:

Firstly, that those who teach nursing theory have an awareness of what the role of the contemporary nurse involves. Bearing in mind that the relationship of the nurse tutor to the areas of actual health care delivery are, at present, tenuous she will not develop an awareness of the nurse's role through familiarity with the contemporary delivery of nursing care. This relative non-involvement of the nurse tutor in real-life situations has been commented on previously by Cormack and Fraser (1975) and by Cormack (1976). The latter paper contrasts the British system with that existing in the U.S.A. where:

"..... those staff who teach the nursing theory also supervise the students in the clinical areas, and give practical instruction during that time." p 400

However, even in the U.S.A., where the clinical supervision of students in the clinical area is carried out by those who teach the theory, the system is not without its critics as was demonstrated in a paper by Mauksch (1980) who wrote of clinical nursing faculty in American Schools of nursing;

"They teach, but although many are superbly prepared nurses, they do not practice Increasingly, students ask whether their teachers are capable of nursing practice" p 21

Alternatively, it might be assumed that an awareness of the contemporary role of the nurse might be obtained from nursing texts dealing with each specialised nursing subject area. This assumption has a number of weaknesses including those outlined below.

1. Writers of nursing texts, particularly in the United Kingdom, may well be as divorced from actual health care delivery as the nurse teachers who use their text-books. For example, relatively few current British nursing texts have been written by nurses with current or very recent practical experience of nursing.

2. The content of nursing texts may not accurately reflect actual work of the nurse. A recent study by Cormack (1975) indicated a gross discrepancy between the prescribed role of the nurse, as described in contemporary literature, and the actual, observed, role. While this study was concerned only with the psychiatric charge nurse, there is much evidence to suggest that the same may be true of nurses working in other grades or specialties. Towell (1975) supported this view when he suggested that "personal relationships", given much emphasis in many recent role prescriptions, was a limited feature of the role of the psychiatric nurse. A second major assumption of the currently used teaching and examination system is that nurses will actually practice nursing in the way they describe it under examination conditions. This long-standing belief was seriously challenged by Bendall (1975) who wrote;

"The findings of this study should lead to a re-thinking of the current examination system. The situation as it exists has been accepted in the belief that a trainee's nursing ability can be assumed from her written papers; in other words that skilled performance can be assumed from recall of information." p 66

While the study by Bendall (1975) related to physical nursing tasks performed within a "general hospital" context, there is little evidence to suggest that the findings would not equally apply to psychiatric and other hospital settings. In response to the recognition of this discrepancy between what nurses are taught and what they practice, Bendall (1975) suggested that, in relation to future research;

"The first and most pressing need is for research into what should actually go into a nursing training syllabus, in terms of what happens in the ward situation." p 68

It is intended that this study will uncover more information relating to "what happens in the ward situation" and that this information may be used to re-examine the content of the psychiatric nurse training syllabus.

THE RESEARCH METHOD IN OPERATION

Two types of data were collected: Documentary Data and Critical Incidents.

Documentary Data

All hospitals participating in the study were asked to provide copies of current documents relating to the training, work and means of assessing each of the six nurse grades forming the subjects of the study. The three types of documentary data are referred to as

- (a) Job descriptions
- (b) Job training syllabi
- (c) Job assessment forms

A personal visit, or phone call, was made to the nursing administrator most likely to be able to provide the required documentary data.

In relation to documents describing the training, work and assessment of student and pupil nurses, the Director of Nurse Education received the request. In relation to the other four grades of staff (nursing assistant, enrolled nurse, staff nurse and charge nurse) the request was directed to the divisional nursing officer. The method of collecting documentary data remained unchanged throughout the pilot and major studies.

Critical incidents

Critical incidents, relating to each of the six nurse grades forming the subjects of the study, were collected from:

Nursing assistants
Pupil nurses
Student nurses
Enrolled nurses
Staff nurses
Charge nurses
Nursing officers

The critical incidents related to one or other of these six nurse grades.

Doctors

Patients (in acute short stay and long stay ambulant wards only)

The critical incidents related to the nurse working on day shift or night shift, and to the nurse working in psychogeriatric wards or acute short stay wards or long stay ambulant wards.

The Pilot Study (Critical incidents)

A Scottish psychiatric hospital containing between six and seven hundred beds and known to be typical of those to be included in the major study was chosen as a pilot for the data collection method. The method of entry to the pilot hospital was similar to that used to enter other hospitals. See Appendix 1 for a detailed discussion of the entry method and its associated problems.

Data were collected from three sources, the method relating to two of these remained unchanged in the major study. The data collection method was changed in relation to the third source. (a). The three sources of "Critical Incidents" were;

(a) Hospital based nursing staff working in wards of the following types:

Geriatric

Acute/Short stay

Long Stay/Ambulant

Nursing staff in the following grades were asked to provide

Critical Incidents:

Nursing assistants

Pupil nurses

Student nurses

Enrolled nurses

Staff nurses

Charge nurses

Nursing officers

(b) Medical staff working in wards of the following types:

Geriatric

Acute/Short Stay

Long Stay/Ambulant

(c) Patients in the following ward types;

Acute/Short Stay

Long Stay/Ambulant

Nurses, patients and medical staff were free to choose the grade or grades of staff who would be the subjects of their critical incidents from the six staff grades who were the subjects of the study.

Data Collection (Pilot)

(a) First Pilot. Response rate from nurses

The writer met with one hundred nurses in Hospital 1 and requested that they participate in his research which was designed to "study the role of the psychiatric nurse". The nurses were met in groups ranging in size from four to thirteen and were given a verbal and written explanation of the study, and a written request for assistance (See Appendix 2). A package containing the following was given to each nurse;

1. A letter containing explanation of research and request for assistance (Appendix 2).
2. Twenty forms (ten "effective" and ten "ineffective") requesting the provision of twenty critical incidents (See Appendices 3a and 3b for one example of each).
3. Four examples of completed data collection forms (See Appendices 4a, b, c, and d).
4. An envelope addressed to the writer.

Questions were invited from the nurses and these were answered by him. Examples of the types of questions raised were, "Is this confidential?" and "Would you like us to complete all the forms", the reply to both was "Yes".

The one hundred nurses who met with the writer were partly a self-selected and convenience sample, the sample was self-selected in that only those nurses who felt "free to participate" did so. It was a convenience sample in that only those nurses who were on duty during the writer's visit to the hospital were asked to participate.

The packages containing twenty forms and enclosures, were distributed to the following numbers and grades of nurses in the first pilot study.

TABLE 2

| Nurses Participating in First Pilot Study (N = 100) | | |
|---|----------------------|---------------------|
| <u>Grade</u> | <u>No. of Nurses</u> | <u>No. of Forms</u> |
| Nursing assistant | 23 | 460 |
| Pupil nurse | 14 | 280 |
| Student nurse | 15 | 300 |
| Enrolled nurse | 13 | 260 |
| Staff nurse | 14 | 280 |
| Charge nurse | 18 | 360 |
| Nursing officer | 3 | 60 |
| | <u>100</u> | <u>2,000</u> |

The writer returned one month later to the arranged "collecting point" in the Nursing Administration Department and collected the following number of forms:

TABLE 3

| Numbers of Nurses returning Packages/forms in the First Pilot Study (N = 13) | | |
|--|---|---|
| <u>Grade</u> | <u>No. of Packages Returned (N = 100)</u> | <u>No. of Forms Returned (N = 2000)</u> |
| Nursing assistant | 3 | 17 |
| Pupil nurse | 2 | 6 |
| Student nurse | 1 | 7 |
| Enrolled nurse | - | - |
| Staff nurse | 4 | 3 |
| Charge nurse | 2 | 9 |
| Nursing officer | 1 | 7 |
| | <u>13 = 13%</u> | <u>49 = 2.45%</u> |

This very low response rate in terms of returned packages and completed forms prompted the carrying out of a second Pilot Study using a method very similar to that used by Jacobs *et al.* (1973). These 49 forms collected in the first Pilot Study were not included in the main data in view of the major differences subsequently used to collect incidents.

Second Pilot. Response rate from nurses

During a three day period of data collection in hospital it was arranged that as many nurses as could be "freed" from ward duties would meet with the writer at a pre-arranged time. Nurses who had participated in the first pilot study were excluded from the second. During this period one hundred and nine nurses met with the writer and were requested to participate in his research work. The request, and explanation of the nature of the study were given both verbally and in writing (see Appendix 5). Each nurse was also given four Critical Incident forms, two effective and two ineffective (See Appendices 3a and 3b), and requested to complete them. Of the one hundred and nine nurses who met with the writer and were requested to provide data, twelve nurses would not or could not participate.

The total number of forms which were provided by the one hundred and nine nurses who were requested to participate in the second pilot study was as follows:

TABLE 4

| Second Pilot Study (Number of Completed Forms from Nurses) (N = 289) | | | | | | |
|---|------------------|-----------|------------------|-----------|------------------|-----------|
| Grade of Completing Nurse | <u>Geriatric</u> | | <u>Long Stay</u> | | <u>Admission</u> | |
| | Eff. | Ineff. | Eff. | Ineff. | Eff. | Ineff. |
| Nursing assistant | 17 | 15 | 8 | 7 | 3 | 2 |
| Pupil nurse | 2 | 2 | - | - | 4 | 2 |
| Student nurse | 4 | 3 | 3 | 3 | 15 | 10 |
| Enrolled nurse | 18 | 16 | 18 | 10 | 3 | 2 |
| Staff nurse | 9 | 6 | 4 | 4 | 12 | 5 |
| Charge nurse | 16 | 15 | 4 | 4 | 13 | 15 |
| Nursing officer | 5 | 5 | 1 | - | 2 | 2 |
| | <u>71</u> | <u>62</u> | <u>38</u> | <u>28</u> | <u>52</u> | <u>38</u> |

Ninety-seven of the one hundred and nine nurses completed forms. The participation rate from the one hundred and nine nurses included in the second pilot study was 89% (compared with 13% in the first pilot). The response rate, in terms of number of completed forms, was 66% (compared with 2.45% in the first pilot).

Second Pilot. Response rate from medical staff

A list of all medical staff in Hospital 1 was obtained from the Nursing Administration office and, in relation to each doctor, the types of wards in which he worked. The list of twelve doctors was then divided into three sub-lists of equal sizes, each sub-list containing the names of doctors working in each of the three specialties:

- (a) Geriatric wards
- (b) Acute/Short Stay wards
- (c) Long Stay/Ambulant wards

Each doctor was sent a package containing:

- (1) An explanation of the nature of the research study and a request for assistance (See Appendix 6).
- (2) Four Critical Incident forms two effective and two ineffective, relating to the role of the ward-based nurse in one of the three specialties mentioned above (See Appendices 7a and 7b).
- (3) A return envelope addressed to the writer.

Four weeks after the medical staff in Hospital 1 had been requested to participate in the study, no forms had been returned. A reminder letter (See Appendix 8) was sent two weeks later and this prompted the return of one package with two completed forms, a response rate of 4%. Despite the very poor response rate it was decided not to change this method of requesting medical participation in the study. It was felt that a significant increase in response rate could not be achieved with an added investment of time and effort which, apart from being unavailable to the writer, may have been out of proportion to the increase in response.

Second Pilot. Response rate from patients

Data were collected from patients in two types of wards:

- (a) Acute/Short Stay wards
- (b) Long Stay/Ambulant wards

Permission to request that individual patients be invited to participate in the study was obtained from the appropriate medical staff (See Appendix 9). Two wards of each of the above two types, one male and one female, were selected by the writer. The nurse in charge of the ward at the time of data collection was requested to invite patients to participate in the study. Patients were to be told that the researcher was a psychiatric nurse presently working as a Lecturer in Nursing Studies and that he was investigating the role of the psychiatric nurse. The nurse-in-charge was requested to invite patients who in his opinion could sit, concentrate and write for fifteen minutes.

The average size of the four wards included in the pilot study are given in TABLE 5.

TABLE 5

| Number of Patients Participating in the Pilot Study (N = 52) | | |
|---|----------------------------|--|
| Ward Type (Two Wards) | Average No. of Patients | Average No. of Participating Patients |
| Acute/Short Stay | 23 | 11.5 |
| Long Stay/ Ambulant | 29 | 13.5 |
| Total | 52 | |

The fifty two patients (from a total of four wards) who participated in the study provided a total of forty-nine forms (see TABLE 6 below).

TABLE 6

| Number of Completed Forms from Patients in Pilot Study (N = 49) | | | | |
|--|------------------|--------|------------------|--------|
| <u>Specialty</u> | <u>Long Stay</u> | | <u>Admission</u> | |
| | Eff. | Ineff. | Eff. | Ineff. |
| | 17 | 2 | 18 | 12 |
| Sub Total | 19 | | 30 | |
| | From 27 | | From 23 | |
| | Patients from | | Patients from | |
| | Two Wards | | Two Wards | |

The number of patients agreeing to participate in the study and providing completed forms, resulted in the decision to continue with this method of collecting data from patients.

The main study: hospital, doctor, patient and nurse sample size

The use of the Critical Incident Technique is not dependent on a fixed maximum number of critical incidents being collected and classified. The optimum number is reached when the incidents collected add no new categories to those already collected and classified. When one hundred critical incidents fail to add a new category to those obtained from those already identified from previously classified critical incidents, the optimum number has been reached (Flanagan 1954). This approach is dependent on the researcher classifying incidents as they are collected and ending the collection when the past one hundred incidents reveal nothing unique.

The approach used by the writer was different in that it was decided to collect a maximum number of critical incidents, classify them and decide whether or not to proceed with additional data collection. In the time available to the writer for data collection, three months at the end of the first year of the three year study, it was decided to collect as many critical incidents as possible, analyse them, and decide whether or not more were required.

Hospital Sample; Main Study

It was estimated that data could be collected from ten hospitals, in addition to Hospital 1 used in the pilot study, during the twelve week period of data collection. This estimate was based on the one week required to collect data from Hospital 1 and took account of the additional time required to travel to the remaining hospitals.

Permission was obtained to collect data in nine of the eleven hospitals, in the two instances where permission was refused, the refusal was given to the writer via the Chief Area Nursing Officer.

In the first instance the letter of refusal said "I have to advise you that X District is not able to assist you at this stage". In the second instance the letter of refusal said "I regret that I cannot offer you the facilities you require at Hospital X".

Following the refusal in respect of two hospitals, a further two hospitals were contacted and permission obtained to enter and collect data, resulting in a total of eleven participating hospitals. Hereafter the eleven hospitals will be referred to as Hospitals 1 - 11.

Information Services Division, Common Services Agency for the Scottish Health Service (1979) shows there to be 37 "Mental Illness" hospitals contained within twelve area health boards in Scotland, the total number of mental illness beds being 18,397 in 1978. The eleven hospitals which were used in the main study contained a total of 8,222 beds, representing 45% of the total beds in Scotland. Data were collected in hospitals situated within eight of the twelve area health boards which had mental illness beds. The eleven hospitals chosen reflected the range of size and geographical distribution of psychiatric hospitals in Scotland. The smallest hospital included in the study had 160 beds, the largest 1,700 beds.

Doctor Sample; Main Study

A total of 118 doctors in eleven hospitals were sent individual requests to participate in the project by providing data on four enclosed forms (See Appendices 7a and 7b). Eleven doctors replied and completed a total of forty one forms.

Patient Sample; Main Study

A total of 462 patients from the acute/short stay and long stay/ambulant specialties participated in the provision of critical incidents, providing a total of 740 completed forms.

Nurse Sample; Main Study

A total of 1164 nurses agreed to provide data as requested. The nurses were distributed through the seven grades as follows;

TABLE 7

| Distribution of participating nurses between grades, number of completed forms from each nurse grade. (N = 3696) | | |
|---|--|---|
| Grade | No. of Nurses Participating (N = 1164) | No. of Completed Forms (N = 3696) |
| Nursing assistants | 341 | 1005 |
| Pupil nurses | 79 | 265 |
| Student nurses | 140 | 471 |
| Enrolled nurses | 261 | 795 |
| Staff nurses | 101 | 329 |
| Charge nurses | 205 | 701 |
| Nursing officers | 37 | 130 |
| Total | 1164 | 3696 |

Table 8 compares the distribution of staff between grades in Scottish psychiatric hospitals, with the distribution of staff between grades participating in this study.

Figures for Scotland relate to whole time staff and are taken from Table 9: 10 Hospital Nursing Staff (Mental) in Information Services Division, Common Services Agency for the Scottish Health Service (1979).

It shows that the distribution by grade of nursing staff participating in this study closely parallels the distribution by grade of whole time nursing staff in Scotland as a whole.

TABLE 8

| Distribution of staff between grades, excluding Nursing Officers, participating in study, and in Scotland | | | | |
|--|---------------------------------------|-------------|------------------------------|-------------|
| Grade | Number participating in this Study | | Number in Scotland (1978) | |
| | | % | | % |
| Charge nurse | 205 | 18.2 | 1353 | 18.9 |
| Staff nurse | 101 | 9 | 577 | 8 |
| Enrolled nurse | 261 | 23.1 | 1480 | 20.6 |
| Student nurse | 140 | 12.4 | 1002 | 14 |
| Pupil nurse | 79 | 7 | 521 | 7.3 |
| Nursing assistant | 341 | 30.3 | 2240 | 31.2 |
| | <u>1127</u> | <u>100%</u> | <u>7173</u> | <u>100%</u> |

Nursing officers, thirty seven of whom participated in the study, are excluded from Table 8 because the data source for Scotland as a whole did not provide information about their numbers. It is clear from Table 8 that the distribution of staff between grades participating in the study is very similar to the distribution of staff between grades in Scotland as a whole.

Unsolicited comments relating to the study

During the data collection phase of the study 251 comments were made which related to the study, or to the general subject of the research. These comments are described and discussed in Appendix 10.

Documentary Data

Each of the eleven hospitals participating in the study were asked to provide a copy of the following documents relating to each of the six nurse grades participating in the study;

- (a) Job description
- (b) Job training syllabus
- (c) Job assessment form

DATA ANALYSIS (CRITICAL INCIDENTS)

Data analysis took two forms, quantitative and qualitative, and will be dealt with in that order.

Quantitative analysis dealt with the numbers of critical incidents and the respondents providing them, for example the numbers of incidents provided by nurses, patients and doctors. This analysis was undertaken in the same order as the items were recorded on the data collection form (see Appendices 3a and 3b). This was followed by a qualitative analysis of the content of the critical incidents.

Shift referred to in critical incident

A total of 4477 incidents was collected from 1637 respondents and related to ward based nursing staff working on all parts of a twenty four hour shift system. All hospitals in the sample had a single night shift operating, for example, from 8 p.m. until 8 a.m. The remaining day hours were typically staffed with one of the following alternatives: a single day shift from 8 a.m. until 8 p.m., or, a two shift system to cover the day time hours viz. 7 a.m. until 2 p.m. and 1.30 p.m. until 9 p.m.

For the purpose of this study the twenty four hour period was considered as consisting of two elements; day shift and night shift.

Nurse respondents were given forms which were pre-coded in terms of the shift to which the critical incidents related. Nurses on night shift could only provide incidents relating to nurses working on night duty, nurses on day shift could only provide incidents relating to nurses working on day duty. Other respondents, patients and doctors, could choose incidents relating to nurses on either shift. TABLE 9 shows the distribution of critical incidents between night shift and day shift.

TABLE 9

| Distribution of critical incidents between shifts (N = 4477) | | |
|---|--------------------------------|-------------------|
| <u>Shift</u> | <u>Number of Incidents</u> | <u>% of Total</u> |
| Night | 930 | 21% |
| Day | 3547 | 79 |
| | <u>4477</u> | <u>100%</u> |

That much larger numbers of forms were provided by, or related to, day staff may be due to a number of factors. Firstly, the longer time span of the day duty period resulted in a greater number of nurses working during that period. Secondly, night shifts invariably had smaller numbers of available nurses than had the same area, for example a ward, during the day shift. In one instance a ward had five staff during each of the two day shifts, and two staff during the night shift. Thirdly, because of the lower staffing levels during night duty, a nurse would often be on her own for all or part of the night and clearly had more difficulty in arranging "time off work" to meet with the writer. Finally, almost all response from patients and medical staff related to nurses working on day duty.

Distribution of incidents between hospitals

The question of hospital identity (numbers 1 to 11) was always pre-coded by the writer. TABLE 10 shows how the 4477 incidents were distributed between the sample of eleven Scottish psychiatric hospitals.

TABLE 10

| Distribution of incidents between hospitals (N = 4477) | | |
|--|---|-----------------------|
| <u>Hospital Number</u> | <u>Number of Critical Incidents</u> | <u>% of Total</u> |
| 1 | 340 | 7.6% |
| 2 | 336 | 7.5 |
| 3 | 336 | 7.5 |
| 4 | 194 | 4.3 |
| 5 | 730 | 16.3 |
| 6 | 616 | 13.8 |
| 7 | 204 | 4.6 |
| 8 | 394 | 8.8 |
| 9 | 429 | 9.6 |
| 10 | 638 | 14.2 |
| 11 | 260 | 5.8 |
| TOTAL = | 4477 | 100 % |

Distribution of incidents by ward type

A feature of Scottish psychiatric hospitals is that adult patients are cared for in one of three ward types, each type constituting approximately one third of the total, a brief description of each is given below;

(a) Psychogeriatric Patients cared for in this type of ward are, in general, suffering from diseases associated with organic psychoses, senile dementia for example. The progressive nature of the organic psychoses and their association with old age result in a distinctive ward population. Patients are, in general, in the sixty to eighty five age group, are more or less confused, have a variety of long term physical disabilities and have an illness which is regarded as being terminal.

A minority of patients will have "graduated" from long-stay ambulant wards, see below, by virtue of having reached an age where physical frailty makes residence in such wards inappropriate, such patients will tend to suffer from a functional, non-organic, psychoses.

(b) Long-stay ambulant Patients cared for in this type of ward are, in general, suffering from chronic functional psychotic illnesses, schizophrenia for example. Although the age range of patients may vary, a common feature will be the long term nature of the current hospitalisation which may vary from one to fifty or more years. The mobility and physical status of the patient may well enable him to move freely in the hospital and grounds, indeed he may be working full time or part time in the hospital or even for an employer outwith the hospital.

(c) Admission, short-stay Patients cared for in this area are, in general, suffering from an acute episode of any of a variety of illnesses, including the neuroses and psychoses. Age range varies from the early teens to late old age and physical status may vary from excellent to very poor depending on the nature of the illness. The period of hospitalisation in this area tends to be short, four to twelve weeks for example, with some patients who are in the immediate pre-discharge phase being relatively "well".

Each critical incident related to one of the three major specialties relating to in-patient psychiatric care and described above:

- (a) Psychogeriatric nursing
- (b) Long-stay ambulant nursing
- (c) Admission, short-stay nursing

TABLE 11 illustrates the distribution of the 4477 critical incidents between the three specialties.

TABLE 11

| Distribution of incidents between specialties (N = 4477) | | |
|---|--------------------------------|-----------------------|
| <u>Specialty</u> | <u>Number of Incidents</u> | <u>% of Total</u> |
| Psychogeriatric | 1669 | 37% |
| Long-stay, ambulant | 1489 | 33 |
| Admission, short-stay | 1319 | 30 |
| | <u>4477</u> | <u>100%</u> |

Despite the fact that patients in the psychogeriatric area were not invited to contribute (patients in the other two specialties providing 740 forms) more forms related to this specialty than to the other two. This may reflect the fact that, in many hospitals, this specialty is larger than each of the other two in terms of patient numbers and larger than the others in terms of staff numbers.

Number of incidents from each respondent group

The status of the reporting person, for example doctor, patient or nurse was the next entry on the form. For doctors and patients the form was pre-coded by the writer, while nurses were requested to enter their grade, for example "nursing assistant", "pupil nurse" or "charge nurse". TABLE 12 shows the distribution of forms according to the three groups of respondents (doctors, patients and nurses). Doctors and nurses were asked to provide a maximum of four incidents, patients a maximum of two.

TABLE 12

| Distribution of incidents between three respondent groups (N = 1637) | | | |
|---|----------------------|---------------------|-----------------------|
| | Nurses (N = 1164) | Doctors (N = 11) | Patients (N = 462) |
| Number of incidents | 3696 | 41 | 740 |
| \bar{X} Number per person | 3.2 | 3.7 | 1.6 |

A further analysis was made of the individual nurse grades, a total of seven, who provided critical incidents. TABLE 13 gives the number of responding nurses in each grade, the total number of incidents they provided and the mean number of incidents from each grade.

TABLE 13

| Distribution of incidents between grades of reporting nurses (N = 1164) | | | | | |
|---|-----------------------------------|-------------------|----------------------------|-------------------|---------------------------|
| <u>Nurse Grade</u> | <u>Number of reporting nurses</u> | <u>% of Total</u> | <u>Number of Incidents</u> | <u>% of Total</u> | <u>X Number per Grade</u> |
| Nursing Assistant | 341 | 29% | 1005 | 27% | 2.9 |
| Pupil Nurse | 79 | 7 | 265 | 7 | 3.3 |
| Student Nurse | 140 | 12 | 471 | 13 | 3.4 |
| Enrolled Nurse | 261 | 22 | 795 | 21 | 3.0 |
| Staff Nurse | 101 | 9 | 329 | 9 | 3.3 |
| Charge Nurse | 205 | 18 | 701 | 19 | 3.4 |
| Nursing Officer | 37 | 3 | 130 | 4 | 3.6 |
| | <u>1164</u> | <u>100%</u> | <u>3696</u> | <u>100%</u> | <u>3.3</u> |

Staff reported on

The reported incidents related to the behaviour of the six grades of staff from nursing assistant to charge nurse. Some respondents reported on "self" in which case the incident was "added to" the grade to which that nurse belonged. Some respondents reported on "all grades", in which case the incident was attributed to all ward based grades of nurse in that hospital. All hospitals had six ward based grades of nurses except hospital 3, which had no student nurse grade. TABLE 14 shows the number of incidents relating to each nurse grade and, in the middle and right hand columns, gives the adjusted distributions arising from the "self" and "all grades" being appropriately

re-distributed.

TABLE 14

| Distribution of incidents between staff reported on (N = 4477) | | | | | | |
|---|--------------------------------|-----------------------|--|-----------------------|--|-----------------------|
| <u>Nurse Grade</u> | <u>Number of Incidents</u> | <u>% of Total</u> | Adjusted distribution to include incidents relating to "all grades" and "self" | | | |
| | | | <u>Adjustment for "All" Incidents</u> | | <u>Adjustment for "self" Incidents</u> | |
| | | | <u>Number</u> | <u>% of Total</u> | <u>Number</u> | <u>% of Total</u> |
| Self | 1639 | 37% | 1639 | 30% | | |
| Nursing Assistant | 476 | 11 | 657 | 12 | 1183 | 22% |
| Pupil Nurse | 123 | 3 | 304 | 6 | 413 | 8 |
| Student Nurse | 262 | 6 | 443 | 8 | 620 | 11 |
| Enrolled Nurse | 493 | 11 | 674 | 13 | 1061 | 20 |
| Staff Nurse | 403 | 9 | 584 | 11 | 728 | 13 |
| Charge Nurse | 900 | 20 | 1081 | 20 | 1387 | 26 |
| All Grades | 181 | 4 | | | | |
| | <u>4477</u> | <u>101%</u> | <u>5392</u> | <u>100%</u> | <u>5392</u> | <u>100%</u> |

The left side of TABLE 14 presents the distribution of critical incidents without adjustment having been made for the fact that a number of incidents relate to "self" (1639 incidents), or that a number of incidents relate to "all grades" (181 incidents). The middle column of TABLE 14 redistributes those incidents relating to "all grades" to the actual grades to which they relate. The final column redistributes those incidents relating to "self" to

the actual grades to which they relate. Future discussion of the distribution of critical incidents between grades will refer only to the final (right side) section of TABLE 14 which deals with the numerical and percentage distribution of critical incidents between grades.

The next question, also pre-coded by the writer, concerned whether the incident related to effective or ineffective nursing care. Patients were asked to provide one example of each, doctors and nurses were asked to provide two of each. TABLE 15 shows the distribution of effective and ineffective incidents.

TABLE 15

| Distribution of effective/ineffective incidents (N = 4477) | | |
|--|---------------|-------------------|
| | <u>Number</u> | <u>% of Total</u> |
| Effective Incidents | 2611 | 58% |
| Ineffective Incidents | 1866 | 42 |
| | <u>4477</u> | <u>100%</u> |

Respondents in this study were asked to provide a predetermined number of critical incidents relating to effective and ineffective nursing. The decision to ask for both types of incidents was made for the following reasons.

First, others who have used the technique, including Flanagan (1954), have collected both types of incidents in the belief that this resulted in a more complete description of the subject of the research. Second, it was anticipated that some aspects of nursing activity might be more easily noticed, or indeed only noticed, when performed ineffectively. Thus, the exclusion of ineffective incidents might have resulted in only a partial description of the role of the psychiatric nurse. For example, one respondent described the administration of medication without medical prescription as being an example of ineffective nursing. It is possible that one

aspect of effective nursing, "administering prescribed medication", may not have been reported on if not done so via an incident relating to ineffective nursing activity. Finally, psychiatric nursing, in common with all nursing, requires to be more aware of those aspects of contemporary functioning which are effective as well as ineffective, The inclusion of ineffective incidents must help to provide criteria for effective nursing.

In discussing their application of the critical incident technique Jacobs et al (1973) state that respondents were asked to provide six incidents each; two effective, two ineffective and two of their choice. They report that the response rate was 4.8 incidents per respondent but do not indicate or make use of the distribution of incidents between effective and ineffective. The implication of this omission is that the overall effective-ineffective distribution was in itself felt to be of no intrinsic value by these writers.

Cunningham (1979) did not describe the numbers of effective/ ineffective incidents which her respondents were asked to provide but did report an equal distribution between incidents 50% effective and 50% ineffective.

Rimon (1979) appears to have given her respondents free choice as to whether to provide effective and/or ineffective incidents, and reports that 96% of the incidents were effective. That writer explains the low percentage of ineffective incidents as being due to nurses' tendency not to report negative incidents which tend to arouse anxiety or which make them appear in an unfavourable light. However, that writer then goes on to conclude that while the 96% level of effective incidents was "encouraging" this should not be taken to infer that 96% of the activity being investigated was successful or positive.

In this study patients were requested to provide one effective and one ineffective incident, non-patient respondents were requested to provide two of each. The total number of incidents, 4477 were distributed as follows;

| | |
|------------------------------|-----|
| Effective incidents (2611) | 58% |
| Ineffective incidents (1866) | 42% |

The higher incidence of effective incidents in the data as a whole may reflect, as Rimon (1979) suggests, the greater reluctance of respondents to report negative incidents. It may be concluded therefore that differing effective-ineffective distributions of incidents between studies using the critical incident technique is a function of the study design, rather than indicative of the effectiveness or otherwise of the subject being reported on.

The present study, like that of Jacobs et al (1973), requested that respondents provide examples of effective and ineffective nursing in the belief that as much can be learned about nursing practice by examining failures as by examining successes. It seems probable that those writers, Rimon (1979) for example, who collected a vast preponderance of one type of incident (96% effective in the case of Rimon (1979)) could have obtained a fuller description of the subject being studied by collecting a more equal proportion of both types of incidents.

The final question of the form "How many days ago did the activity occur" implied a reply relating to a more, rather than less, recent incident. Despite a request for this information a number of forms (25%) contained no detail of the length of time since the incident occurred. TABLE 16 shows the distribution of forms between differing time intervals.

TABLE 16

| Distribution of incidents between time intervals (N = 4477) | | |
|--|--------------------------------|-----------------------|
| <u>Number of days since incident occurred</u> | <u>Number of Incidents</u> | <u>% of Total</u> |
| 1 - 7 days | 1520 | 34% |
| 8 - 28 days | 846 | 19 |
| More than 28 days | 980 | 22 |
| Not specified | 1131 | 25 |

Critical incidents: Developing a classification system

After incidents were collected a classification system was designed initially by the writer to summarise them. The system has three levels of specificity and followed the model used by Jacobs *et al.* (1973). The three levels of the system, similar to those used by Jacobs *et al.* (1973) were;

- (i) AREA e.g. "STAFF INITIATED THERAPEUTIC INTERVENTION" which is the least specific level of classification.
- (ii) Category e.g. "Uses Self As A Therapeutic Tool" which is the intermediate level of specificity in the classification system, and
- (iii) Sub-category e.g. "Makes self available to patients" which is the most specific level of the classification system.

The decision to use a three level classification system was based on the following factors. First the clarity of presentation achieved by others, Jacobs *et al.* (1973) for example, in summarising complex data in a three level classification system pointed to the usefulness of that approach. Second, the use of a three level system of classification allows complex data to be compartmentalised for the purpose of description, analysis and discussion. Third, a three level system may be regarded as a compromise between a single level classification which lacks specificity, and one with an even

larger number of levels, ten for example, which is over specific and does not allow generalisations to be made. Finally, initial work in identifying an appropriate number of levels for the classification system suggested that three levels would be practical and enable the data to be described, analysed and discussed with a level of specificity appropriate to this study.

The decision to use a three level classification system emerged along with decisions regarding the "labels" which should be given to each part of each level of the system. For example, examination of a number of, as yet, unclassified critical incidents suggested that all might be contained in a system with four general AREAS as follows;

AREA A "STAFF INITIATED THERAPEUTIC INTERVENTION"

AREA B "ADMINISTRATIVE ACTIVITY"

AREA C "GIVES PHYSICAL CARE"

AREA D "PERSONNEL FUNCTION"

As incidents were classified with regard to AREA it became clear that each AREA required further sub division. For example, in relation to AREA A "STAFF INITIATED THERAPEUTIC INTERVENTION" some incidents related to using self as a therapeutic tool or making therapeutic use of the environment. Thus, sub-division of AREAS into Categories became necessary. For example, AREA A contains the following five Categories:

Category I "Uses Self As A Therapeutic Tool"

Category II "Makes Therapeutic Use Of Environment"

Category III "Effectively Deals With Or Communicates With Relatives"

Category IV "Effectively Responds To Patients' Pathological Behaviour"

Category V "Functions As Part Of A Therapeutic Team"

As with the AREA, Categories lacked the specificity required to give full meaning and description to their contents. The following example of the allocation of three Sub-categories to Category III (above) will illustrate the point;

- Category III "Effectively Deals With Or Communicates with Relatives"
- Sub-category 1 "Gives relatives correct explanation of, or information relating to, patients illness, treatment or nursing care"
- Sub-category 2 "Comforts relatives of dying patient"
- Sub-category 3 "Encourages or enables relatives to play an active part in care"

As further incidents were classified the classification system was, when necessary, extended to accommodate incidents which would not "fit in" to the existing system. In practice this extension of the system became less and less necessary as the classification of critical incidents proceeded.

It is not being suggested that the classification system developed by the writer is the only, or indeed the best, possible method. Flanagan (1954) comments, as do others, on the subjectivity involved in developing such a classification system. The system which has been developed and used by the writer is presented as one means of classifying critical incidents of the type collected for this study. In view of the subjectivity of the constructed classification system, and of the judgement used in operating it (using it to classify incidents) it was decided to test the extent to which independent judges would agree or disagree with the writer when classifying incidents independently of him.

The degree of subjectivity in data classification is influenced by the subjectivity or objectivity of the data. For example, data obtained by asking the question "How tall are you?" will facilitate a more objective classification than will data obtained by asking a respondent "How is nursing care evaluated?" Questions of the former type are often referred to as "closed questions" while the latter are often referred to as "open questions".

A major problem encountered in the classification of data collected using the "open questions" method is the measurement of the degree to which other independent classifiers (raters) would agree or disagree with each other, or with the person who is classifying all the data. This measure of agreement is referred to as "INTER-RATER-RELIABILITY (IRR)" and is important for at least

two reasons. Firstly, if one set of data is being classified by a number of raters it is desirable that different raters place a given item in the same part of the classification system. Secondly, if one person is classifying the data, they may wish to measure the extent to which others agree with how individual items are classified. One method of testing this is to ask some independent raters to classify the data and to compare their rating with that of the original rater. In both instances the measurement of IRR reflects the measure of objectivity achieved in the individual ratings.

It was recognised, prior to the development of the classification system, that it would have to satisfy the following conditions;

- (a) The system would have to be a comprehensive description of the work of the psychiatric nurse as contained in the Critical Incidents.
- (b) Categories in the system would have to be mutually exclusive.
- (c) The system would have to be meaningful to those familiar with psychiatric nursing.
- (d) Raters familiar with psychiatric nursing and working independently of the writer would have to achieve a significant level of agreement with him when coding the data using his pre-designed classification scheme. In short, the classification system would require to have a significant level of reliability.

The Measurement of Reliability

In relation to (c) and (d) above, a measure of the extent to which IRR existed was required. In relation to this the relevant literature was reviewed, including the coding of "open end" data in general and critical incidents in particular. A paper by Crano and Brewer (1973), typical of many, focused attention on the need for measuring IRR where more than one coder was used and suggested that

"The failure to present inter-coder reliabilities in a report seriously compromises the credibility of the findings." p 208.

A number of other writers, for example, Boyajy *et al.* (1949), Hoinville *et al.* (1978), Howell (1976), Blum and Naylor (1968), Moser and Kalton (1977) and Flanagan (1954), were equally positive about the need to measure IRR but were equally vague about the means of doing so. In contrast to the vagueness surrounding the means of measuring the IRR of the "open" type of question, much has been written about the measurement of IRR relating to data of the "closed question" type. See Sussman and Haug (1967), Parten (1950) and Hansen (1952).

The relative difficulty of coding "open" as opposed to "closed" type data is reflected in the following comment by Morrissey (1974).

"The coding of open end or "free story" answers requires more skill as well as knowledge of the survey topic than does coding of more objective and systematically collected data." p 459

In another paper Warwick and Lininger (1975) did go some way towards describing a means of examining but not measuring IRR when classifying "open ended" type data. They suggested that

"..... the study directors can review the results ... and attempt to clarify the discrepancies which emerge Only by having two or more persons code the same question is it possible to know whether the code is understood and used consistently." p 251-252

However, this type of subjective measure of IRR leaves much to be desired. For example, those with an interest in achieving a high level of IRR may, consciously or unconsciously, judge the level of agreement to be higher than it actually is.

The problems relating to measuring IRR when classifying open end data have been given serious consideration by relatively few writers. Durbin and Stuart (1954) described an experiment which concluded that the IRR was very much more difficult to achieve where open end material was concerned and much easier when closed question material was being coded. The writers of that paper concluded by suggesting that:

"... variations between coders are best eliminated by substituting pre-coded for open ended questions. This would certainly save time but in other respects seems to us to be undesirable ... In one form or another, the problems of variations in coding must remain whatever techniques are used." p 66

In designing the above experiment, the writers took account of a similar experiment conducted six years earlier by Woodward and Franzen (1948) when open ended questions were placed in a coding frame by three independent judges. The percentage frequency with which these judges placed items into particular parts of the coding frame was compared and used as a measure of IRR. However, although the three judges placed almost identical numbers of responses in particular parts of the coding frame, it is not clear whether the responses so coded were indeed the same ones.

Another comparison by Land and Spilerman (1975) found that independent coders selected the same code, from twelve possible codes, about 75% of the time when coding replies to open ended questions. They also emphasised the fundamental importance of achieving an acceptable level of IRR when devising a classification scheme. They highlighted the difficulties associated with the measurement of IRR when classifying open end data.

"When attention turns to the open ended questions, comparability in coding between surveys or the consistency with which responses can be categorised becomes a major issue." p 139

They hypothesised that the differences in survey findings, or changes over time, may be due to changes in IRR rather than changes in the data.

In a paper entitled "A Critique of Herzberg's Incident Classification System and a Suggested Revision" by Schneider and Locke (1971) a different although equally important issue was raised. It was argued that resulting theory may not be an artifact of the critical incident method, but rather of the system used to classify the incidents.

Despite this long recognition of the need to examine and measure IRR, and of the possible grave consequences of failing to do so, it continues to be given little attention by many writers. For example in discussing use of the Critical Incident Technique in relation to the work of the nurse, Fivars and Gonsell (1966) dealt with the question of IRR as follows:

"The thing to do is to submit the list of categories to other qualified persons for their review" p 19

Another major work by Jacobs *et al.* (1973) made a similarly brief reference to IRR when reporting a large scale study of psychiatric nursing using Critical Incident Technique.

"The incidents were classified by two individuals"

The reliability of classification was assessed at an early stage in the evolution of the classification scheme.

One hundred incidents were pulled randomly from each of the two classifications and were classified independently by four individuals, Percentage agreement with the initial classification ranged from 61% to 80%, Based on this analysis, the category structure was revised and a repetition of the reliability check, using the same incidents, resulted in an overall agreement of 83%." p 15

Thus this relatively recent survey of the work of the American psychiatric nurse, using Flanagan's Critical Incident Technique, used percentage agreement of allocation to categories between raters as a measure of inter-rater reliability.

Many years earlier, in a paper concerned with the reliability of content analysis, Scott (1955) was particularly critical of the "percentage agreement" as a means of measuring inter-rater reliability. One problem with simply using the percentage level of agreement is that it takes no account of the length of the classification system. Clearly, a system with only two categories will, by chance, result in a much greater level of agreement than would a system with twenty categories. He suggested an improved method which involved taking account of the number of categories in the code, and the frequency with which each is used.

In a more recent paper Cohen (1960) developed the method described above still further and included means of estimating the standard error. It presents a coefficient of interjudge agreement for nominal scales:

$$K = \frac{Po - Pe}{1 - Pe}$$

where Po = the proportion of units in which the judges agreed, and Pe = the proportion of units for which agreement is expected by chance.

When K is computed it can then be tested for significance, that is the degree to which a given value of K exceeds chance agreement. In the writer's study inter-rater reliability was measured, using this statistic. It compared coding by the writer with that of two independent coders, both of whom were familiar with psychiatric nursing. A significance level of $P < .05$ was accepted as indicating significant agreement between the writer and independent judges. (See Appendix 11 for the results of the IRR tests) In all instances the level of agreement between the writer and the independent judges was greater than, or equal to, the minimum acceptable level of $P < .05$. Whilst, in general terms, K representing the percentage agreement excluding chance (see Cohen 1960) between the writer and independent judges was statistically significant on all occasions, there were instances where it was less than fifty percent. Examples are:

| | <u>Kappa</u> % agreement (excluding chance) |
|---------------------------------------|---|
| Sub-categories in AREA A, Category I | .38 |
| Sub-categories in AREA A, Category II | .37 |
| Sub-categories in AREA A, Category IV | .37 |
| Sub-categories in AREA A, Category V | .46 |

Percentage agreement, excluding chance, tended to be lower at Sub-category level than at AREA and Category levels. Thus, despite the statistical significance of the level of agreement between the writer and both independent judges in all instances, and at all levels, it is recognised that some caution requires to be exercised in relation to interpreting critical incidents when

classified at Sub-category level. It would be necessary to replicate this study, including the measurement of inter-rater reliability, to finally determine the extent to which the classification of incidents, particularly at Sub-category level, is reliable and useful.

In summary it is clear that the measurement of IRR in relation to the open end type data collected by the writer was both essential and difficult. It is also clear that many writers, while acknowledging the need to measure IRR failed to do so. Others who have measured IRR used techniques, for example a straightforward measure of percentage agreement, which were previously considered to be inappropriate by some researchers.

The use of the K statistic described by Cohen (1960) has several distinct advantages over other measures of IRR. Firstly, it makes fewest assumptions about the frequency of category use. Secondly, it takes account of the length of the classification system. Thirdly, it gives a means of measuring the significance of a given level of agreement.

In this study inter-rater reliability was calculated using a three phase procedure which was preceded by a construction by the author of a three tier classification framework designed to contain the data.

PHASE ONE The first one hundred critical incidents collected and coded by the writer using his classification framework were transferred in typescript to critical incident collection forms. The classifications which the writer had allocated to these critical incidents were not recorded on the typescript copies.

The one hundred critical incidents, with a description of the 4 Areas decided on by the author, were given to each of two independent coders. When each of the two independent coders had each classified their one hundred incidents for AREA, the measure of inter-rater reliability between the writer and each of the two independent coders was calculated. (See Appendix 11 for I.R.R. results)

Having now achieved a significant level of I.R.R. at AREA level, phase two of the process was applied. The application of I.R.R. measurement described in phase two below was dependent on

the condition that agreement at AREA level had been achieved. Thus, the measure of I.R.R. described in phase two was conditional on agreement having been reached at AREA level.

PHASE TWO The next two hundred critical incidents collected and coded by the writer were transferred in typescript to critical incident collection forms. The AREA classification which the writer had allocated to these critical incidents was recorded on these typescript copies, but the Category and Sub-category classifications were not.

The two hundred critical incidents, pre-coded for AREA only were arranged in four groups, relating to AREA A, B, C and D. Each of the four groups of critical incidents were given to two independent coders along with a description of the Categories relating to the AREA in which all of their incidents had been pre-coded.

When each group of incidents, pre-coded for AREAS A, B, C or D, had been classified for Category by the two independent coders, the measure of I.R.R. between the writer and each of the two independent coders was calculated. (See Appendix 11 for I.R.R. results)

Having now achieved a significant level of I.R.R. at AREA and Category level, phase three of the process was applied. The application of I.R.R. measurement described in phase three below was dependent on the condition that agreement at AREA and Category levels had been achieved. Thus, the measure of I.R.R. described in phase three was conditional on agreement having been reached at AREA and Category levels.

PHASE THREE The next three hundred critical incidents collected and coded by the writer were transferred in typescript to critical incident collection forms. The AREA and Category classification which the writer had allocated to these incidents were recorded on these typescript copies, but the Sub-category classification was not.

The three hundred critical incidents, pre-coded for AREA and Category were arranged in ten groups each corresponding to a Category within the classification system; AREA A Category 1, for example. Each of the ten groups of critical incidents were given to two

independent coders along with a description of the Sub-categories relating to the AREA and Category in which all their incidents had been pre-coded.

When each group of incidents, pre-coded for AREA and Category, had been classified for Sub-category by the two independent coders, the measure of I.R.R. between the writer and each of the two independent coders was calculated. (See Appendix 11 for I.R.R. results)

Inter-rater reliability was calculated for all parts of the classification system with the exception of two Categories (B II and D II) each of which contained only one Sub-category and therefore offered no choice of classification for Sub-category.

It is recognised that the method used to calculate I.R.R. can be said to inflate the "natural" reliability at Category and Sub-category levels since, for each of the independent coders, some restriction of choice had been imposed by the writer by the pre-determination of AREA or AREA and Category. The "true" reliability of the coding system would require that the independent coders have the entire three level classification system available to them. However, this would also have greatly increased the complexity of the task. Also, it was thought more appropriate and practical to assess reliability at each level separately using the procedure described. It would be advisable, however, before finally accepting the classification system, and the measure of I.R.R.; that an analysis of "free choice" reliability be performed.

Figure 2 below shows the distribution of the 4477 incidents throughout the parts of the classification system. In order to optimise clarity when using the classification system, the following conventions will be used;

AREAS will be labelled thus:

"AREA A, B, C or D." and will be written as follows;

"STAFF INITIATED THERAPEUTIC INTERVENTION"

Categories will be labelled thus;

"Category I, II, III, IV or V" and will be written as follows;

"Uses Self As A Therapeutic Tool"

Sub-categories will be labelled thus;

"Sub-category 1, 2, 3, 4, 5 etc" and will be written as follows;

"Makes self available to patients"

FIGURE 2

CATEGORISED CRITICAL INCIDENTS (N = 4477)

| <u>AREA</u> | <u>Category</u> | <u>N =</u> |
|-------------|---|------------|
| A | "STAFF INITIATED THERAPEUTIC INTERVENTION" | (3210) |
| A | I "Uses Self As A Therapeutic Tool" | (1497) |
| A | I <u>Sub-categories 1 - 16</u> | |
| | 1. Makes self available to patients. | (15) |
| | 2. Provides opportunities, or encourages patients to talk about their problems. | (138) |
| | 3. Is warm, understanding and sympathetic towards patients. Delivers care with sensitivity and demonstrates empathy. | (317) |
| | 4. Reassures patient. Encourages feeling of confidence, security or optimism. | (67) |
| | 5. Plans or encourages specific one-to-one nurse-patient relationship. | (75) |
| | 6. Recognises, and encourages patients' individuality. Emphasises worth of patient and maximises level of self esteem. | (64) |
| | 7. Encourages or provides social stimulation. Exposes patient to institutional or non-institutional social experiences. | (355) |
| | 8. Minimises patients' communication difficulties. | (21) |
| | 9. Recognises personal limitations when using self as a therapeutic tool. | (12) |
| | 10. Gives patient explanation of treatment, nursing care or nursing decisions. | (82) |
| | 11. Identifies patients' intellectual, spiritual or social needs or limitations. | (26) |
| | 12. Encourages patient to accept treatment or nursing care. | (114) |
| | 13. Maximises staff-patient trust. | (48) |

| <u>AREA</u> | <u>Category</u> | <u>N =</u> |
|-------------|---|------------|
| | 14. Chooses appropriate nursing care. | (133) |
| | 15. Presents self as a role model to patients. | (1) |
| | 16. Is consistent in delivery of care. | (29) |
| A | II "Makes Therapeutic Use of Environment" | (860) |
| A | II <u>Sub-categories 1 - 7</u> | |
| | 1. Encourages patient-patient understanding and relationships. | (19) |
| | 2. Encourages or facilitates patients playing an active part in treatment or self care. Encourages independence. | (422) |
| | 3. Maximises patients' privacy. | (14) |
| | 4. Individualises patient care. Adapts the environment and routine or care to suit individual patients. | (257) |
| | 5. Introduces patient to ward rules, geography staff or other patients. | (34) |
| | 6. Observes or supervises patients. | (80) |
| | 7. Makes therapeutic use of staff-patient or patient-patient groups. | (34) |
| A | III "Effectively Deals With Or Communicates With Relatives" | (80) |
| A | III <u>Sub-categories 1 - 3</u> | |
| | 1. Gives relatives correct explanation of, or information relating to, patients illness, treatment or nursing care. | (27) |

| <u>AREA</u> | <u>Category</u> | | <u>N =</u> |
|-------------|-----------------|---|------------|
| | | 2. Comforts relatives of dying patient. | (6) |
| | | 3. Encourages or enables relatives to play an active part in care. | (47) |
| A | IV | "Effectively Responds To Patients' Pathological Behaviour" | (448) |
| A | IV | <u>Sub-categories 1 - 7</u> | |
| | | 1. Responds to aggressive behaviour. | (149) |
| | | 2. Establishes cause of pathological behaviour. | (33) |
| | | 3. Focuses patient on reality. Gives patient orientation. | (55) |
| | | 4. Sets limits on patients' behaviour. | (10) |
| | | 5. Responds to patients' anxiety, over-activity or over-stimulation. | (111) |
| | | 6. Negatively reinforces pathological behaviour. | (82) |
| | | 7. Anticipates and minimises, or prevents, pathological behaviour. | (8) |
| A | V | "Functions As Part Of A Therapeutic Team" | (325) |
| A | V | <u>Sub-categories 1 - 2</u> | |
| | | 1. Complies with treatment programme or approach agreed by the team. | (100) |
| | | 2. Keeps self and others aware of clinical data relating to the patient. Obtains or encourages, when necessary, non-nursing care for the patient, for example from doctor or chiropodist. | (225) |

| <u>AREA</u> | <u>Category</u> | | <u>N =</u> |
|-------------|-----------------|--|------------|
| B | | "ADMINISTRATIVE ACTIVITY" | (N = 91) |
| B | I | "Ensures Availability of Non-Clinical Patient Data" | (18) |
| B | I | <u>Sub-categories 1 - 2</u> | |
| | | 1. Is aware of the identity of patients. | (13) |
| | | 2. Is familiar, when necessary, with the location of patients in her care. | (5) |
| B | II | "Ensures That Adequate Stocks of Equipment And Supplies Are Available" | (42) |
| B | II | <u>Sub-categories 1 only</u> | |
| | | 1. Ensures that available stocks of equipment and supplies are available. | (42) |
| B | III | "Protects And Secures Patients' Property" | (31) |
| B | III | <u>Sub-categories 1 - 3</u> | |
| | | 1. Arranges for, or offers security for, patients' property. Maintains current list of property and informs patients, when necessary, of location of property. | (20) |
| | | 2. Shows respect and concern for patients' property. | (6) |
| | | 3. Arranges for laundering or repair of clothing. | (5) |

| <u>AREA</u> | <u>Category</u> | | <u>N =</u> |
|-------------|-----------------|---|------------|
| C | | "PROVIDES, PLANS FOR, OR MONITORS PHYSICAL CARE" | (N = 874) |
| C | I | "Administers Medications" | (113) |
| C | I | <u>Sub-categories 1 - 3</u> | |
| | | 1. Administers medications carefully, accurately and as prescribed. | (86) |
| | | 2. Ensures, by observation or assistance, that medications are taken. | (22) |
| | | 3. Observes and monitors side effects of medications. | (5) |
| C | II | "Gives Physical Care" | (761) |
| C | II | <u>Sub-categories 1 - 7</u> | |
| | | 1. Monitors physical health of patient. | (39) |
| | | 2. Selects or initiates appropriate physical care. | (513) |
| | | 3. Recognises personal limitations when delivering physical care. | (27) |
| | | 4. Is aware of patients' treatments, physical needs and care. | (28) |
| | | 5. Plans physical care or treatment in advance of it being delivered. | (10) |
| | | 6. Promotes sleep. | (91) |
| | | 7. Protects patients from a potentially dangerous environment. Removes potentially harmful items from the environment. | (53) |

| <u>AREA</u> | <u>Category</u> | | <u>N =</u> |
|-------------|-----------------|--|------------|
| D | | "PERSONNEL FUNCTION" | (302) |
| D | I | "Maximises Staff Contribution" | (211) |
| D | I | <u>Sub-categories 1 - 4</u> | |
| | | 1. Encourages, accepts and uses staff suggestions. Discusses proposed changes with staff. | (15) |
| | | 2. Arranges workload or work routine to maximise staff effectiveness and/or patient care. | (47) |
| | | 3. Makes optimum use of personal skills, encourages others to do so. | (107) |
| | | 4. Reports on staff changes or shortages to senior staff and/or ensures adequate numbers of nursing staff. | (42) |
| D | II | "Teaches, Counsels Or Gives Orientation To Staff" | (91) |
| D | II | <u>Sub-category 1 only</u> | |
| | | 1. Teaches, counsels or gives orientation to staff. | (91) |

Footnote

Categories B II and D II each have only one Sub-category, B II 1 and D II 1 respectively, therefore the critical incidents classified as D II are identical to those classified D II 1. Similarly, those classified B II are identical to those classified B II 1.

The decision to construct a Sub-category for each of the above two Categories was taken in order to achieve standardisation in that all incidents would be classified for AREA, Category and Sub-category.

Description of classified critical incidents

The purpose of this section is to describe the content of each part of the classification system, the number of incidents placed in each part and the distribution of incidents between shifts, specialties, staff reported on and the numbers of incidents being "effective" or "ineffective". The following abbreviations will be used in the table relating to each part of the classification system;

| | | |
|----------|---|-----------------------------|
| Night | = | Night shift |
| Day | = | Day shift |
| Ger. | = | Geriatric nursing specialty |
| Long St. | = | Long stay nursing specialty |
| Acute | = | Acute nursing specialty |
| Eff. | = | Effective incident |
| Ineff. | = | Ineffective incident |
| C.N. | = | Charge nurse |
| Sf.N. | = | Staff nurse |
| E.N. | = | Enrolled nurse |
| St.N. | = | Student nurse |
| P.N. | = | Pupil Nurse |
| N.A. | = | Nursing Assistant |
| N.O. | = | Nursing officer |
| Pt. | = | Patient |
| Dr. | = | Doctor |

In order to aid description of the content of the system abstracts of selected incidents will be presented. Justifying the presentation of abstracts, rather than the complete incidents, Jacobs *et al.* (1973) wrote:

"Since space precluded reproduction of the complete critical incidents as they were reported, it was necessary to abstract the incidents into short summary statements. We tried to retain as much of the original context and flavor as possible. Without doubt, we were not entirely successful, but it is hoped that the abstracts have retained the essential information of the original reports." p 17

The example below indicates how incidents will be abstracted in this report;

Reported incident unedited

"A young patient was admitted to my ward early last week. I was on days off at the time but I made a point of speaking to her on my first day back on the ward. She seemed very shy with people, including other patients, and spent most of her time reading books or watching television. I got the feeling she didn't want to talk to me but I just persevered.

I made a point of spending more time in her company trying to get her to be comfortable with me. Sometimes we went for a walk or played cards in the ward. She didn't really say much at first but she soon began to seem slightly more relaxed and more talkative. This went on over quite a number of weeks, I made a point of spending time with her once or twice every day.

In time she began to really feel more comfortable with me and told me much more about herself and her problems. She told me things that she hadn't mentioned to anyone else and agreed to me informing other staff. I think developing this one-to-one relationship with this particular patient resulted in much more being known about her illness. I also feel I was able to use it to help this young woman."

ABSTRACT

"A patient was recently admitted to my ward. She seemed very shy and spent most of her time reading or watching television. I spent a lot of time with her over a number of weeks. She eventually began to feel more comfortable with me, talking more about herself and her problems and agreeing that I share the information with other staff. I think this one-to-one relationship helped the patient and resulted in much more being learned about her illness."

Clearly, the larger the number of abstracts presented, the greater will be the readers understanding of the elements of the classification system. However, in the interest of brevity, the number of examples from each part of the classification will not exceed two.

The choice of presented examples will depend on two criteria. Firstly, that the total examples presented are, as far as can be gauged, representative of both shifts, all three specialties, all staff grades and patients, and of effective and ineffective incidents. Secondly, those which give a clear and comprehensive description of the activity will be chosen, rather than the over-brief and less clear description.

The presentation of data will commence with the title of the AREA, Category or Sub-category and will be followed by an abstract or abstracts. A table showing the number of incidents, and their distribution between shift, specialty, staff reported on, and effective/ineffective incidents will follow. Where the numbers of incidents enabled it, a chi square test was applied to determine whether the distribution of incidents differed significantly from that expected. Features of the application of the chi square were as follows;

The expected distribution was derived from the observed percentage distribution of the items in the next highest level in the three tier classification system. For example, the distribution of incidents between shifts in the whole data were as follows;

| <u>Night Shift</u> | <u>Day Shift</u> |
|--------------------|------------------|
| 930 (20.77%) | 3547 (79.23%) |

Thus, the EXPECTED FREQUENCY for the distribution of incidents between shifts in each of four AREAS became 20.77 for night shift and 79.23 for day shift. The chi square was only applied where the number in the EXPECTED OUTCOME cells, was not less than 5. The chi square (X^2) result was regarded as significant if equal to or greater than the value at the 0.05 level of significance and taking account of the appropriate degrees of freedom as follows;

- 1 degree of freedom when the Chi Square related to (two) shifts
- 2 degrees of freedom when the Chi Square related to (three) specialties
- 5 degrees of freedom when the Chi Square related to (six) staff grades
- 1 degree of freedom when the Chi Square related to effective/ineffective incidents

The χ^2 result is described as being either significant (S) or not significant (N.S.)

The numbers relating to "Staff reported on" are frequently greater than for "Shift", "Specialty" and "Effective/Ineffective", this results from some incidents relating to more than one staff grade.

The chi square test establishes whether or not the distribution of incidents differed significantly from that expected. Where the χ^2 shows a significant difference to exist, for example between shifts, an asterisk (*) will be placed above the item or items which were greater than the expected level; the item, or items, which were less than expected will have no asterisk. The purpose of this device is to draw attention to those items which are numerically greater, or lesser, than expected. However, in order to inform the reader of the actual differences between observed and expected frequencies, both will be shown in each table where a ' χ^2 ' was performed. The following abbreviations will be used to facilitate brevity;

O = Observed frequency

E = Expected frequency

Finally, a brief comment will be made on the content of the AREA, Category, or Sub-category and on the outcome of the χ^2 test.

The total number of incidents was distributed as follows;

| <u>Shift</u> (N = 4477) | | <u>Specialty</u> (N = 4477) | | | <u>Eff. Ineff</u> (N = 4477) | |
|-------------------------|----------|-----------------------------|----------|----------|------------------------------|----------|
| Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| 930 | 3547 | 1669 | 1489 | 1319 | 2611 | 1866 |
| (20.77%) | (79.23%) | (37.28%) | (33.26%) | (29.46%) | (58.32%) | (41.68%) |

| <u>Staff reported on</u> (N = 5392) | | | | | |
|-------------------------------------|----------|----------|----------|---------|----------|
| C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| 1387 | 728 | 1061 | 620 | 413 | 1183 |
| (25.72%) | (13.50%) | (19.68%) | (11.50%) | (7.66%) | (21.94%) |

Patient Respondents 740. Other Respondents 3737.

AREA A "STAFF INITIATED INTERVENTION" (N = 3210)

ABSTRACT (Eff. P.N. reporting on P.N. Acute)

"A patient who was blind, deaf and dumb, was totally unable to communicate with staff or other patients. At times he would become very agitated and depressed.

The pupil nurse took it upon himself to learn a sign language which the patient understood. This helped to reduce the patient's communication difficulties, he also became noticeably less agitated and depressed, it also encouraged other members of the staff to learn to communicate with this particular patient."

ABSTRACT (Ineff. E.N. reporting on Self. Ger.)

"I was assigned to look after patients in the lounge area. This should involve observation and toileting of patients. It should also involve the nurse trying to occupy the patients and in providing stimulation by way of games etc.

However, after the toilet round we simply sit around and talk to other nurses. We do not provide any stimulation or therapy for the patients, they are just left to sit and stare into space."

| | <u>Shift</u> (N = 3210) | | <u>Specialty</u> (N = 3210) | | | <u>Eff. Ineff.</u> (N = 3210) | |
|----|--------------------------|-------|-----------------------------|----------|-------|-------------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 570 | 2640* | 1040 | 1125* | 1045* | 1924 | 1286 |
| E. | 667 | 2543 | 1196 | 1068 | 946 | 1872 | 1338 |
| | (X ² = 17.8S) | | (X ² = 33.7S) | | | (X ² = 3.5 N.S.) | |

| | <u>Staff reported on</u> (N = 3970) | | | | | |
|----|-------------------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 1016 | 540 | 781 | 484 | 327 | 822 |
| E. | 1021 | 536 | 782 | 457 | 304 | 872 |
| | (X ² = 6.3 N.S.) | | | | | |

Patient respondents 584. Other Respondents 2626.

AREA A contains the greatest proportion of all incidents (71.7%) of all four AREAS. This is probably not surprising in view of AREA A containing incidents relating to how nurses use their personal skills in relation to the non-physical aspects of care. The incidents, though widely spread between shifts, were significantly

greater in relation to day shift, this probably reflects the greater opportunity for this type of care on day shift. However, as will be seen below this day shift emphasis does not hold good for all Categories or Sub-categories within AREA A.

The Acute and Long stay specialties were over-represented in relation to AREA A incidents, although 32.4% of the incidents related to the geriatric specialty. However, as with the day shift emphasis, the specialty emphasis did hold good throughout the AREA.

All staff grades featured in AREA A incidents, the χ^2 showing no significant differences between grades, however, this did not hold true throughout.

The five Categories within AREA A are as follows;

- I "Uses Self As A Therapeutic Tool"
- II "Makes Therapeutic Use Of Environment"
- III "Effectively Deals With, Or Communicates With, Relatives"
- IV "Effectively Responds To Patients' Pathological Behaviour"
- V "Functions As Part Of A Therapeutic Team"

Each of the above five Categories, and the Sub-categories within them, will be described in turn.

AREA A Category I "Uses Self As A Therapeutic Tool" (N = 1497)

ABSTRACT (Eff. Pt. reporting on E.N. Acute)

"We were all sitting around the ward doing nothing. The nurse organised a game of charades. She created a really companionable atmosphere, it seemed to release the tension in the ward."

ABSTRACT (Ineff. E.N. reporting on N.A. Ger.)

"We were sitting around chatting with some patients. The nurse began to tease a patient about "messaging her pants", the old lady soon became moody and aggressive. She became very upset and wanted to go home, the patient was difficult to nurse for the rest of the day."

| | <u>Shift</u> (N = 1497) | | <u>Specialty</u> (N = 1497) | | | <u>Eff. Ineff.</u> (N = 1497) | |
|----|-------------------------|-------|-----------------------------|----------|-------|-------------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 228 | 1269* | 383 | 541* | 573* | 982* | 515 |
| E. | 266 | 1231 | 485 | 525 | 487 | 897 | 600 |
| | (X ² = 6.6S) | | (X ² = 37.1S) | | | (X ² = 20.1S) | |

| <u>Staff reported on</u> (N = 1927) | | | | | | |
|-------------------------------------|-----------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 483 | 278 | 358 | 247 | 179 | 382 |
| E. | 493 | 262 | 379 | 235 | 159 | 399 |
| | (X ² = 6.2 N.S.) | | | | | |

Patient respondents 443. Other respondents 1054

The X² did not detect a significant difference between staff grades who were reported on. As the table suggests, all grades were widely involved in this area of work. Day shift, long stay and acute specialties had a greater than expected number of incidents in this Category. The number of effective incidents was also greater than expected, constituting 65% of the total. The significantly greater number of incidents in the effective classification, may be indicative of the psychiatric nurse having a special contribution to make in this type of care. However, as will be seen below, this emphasis on effective incidents, does not hold good for all Sub-categories within this Category.

AREA A Category I Sub-category 1

"Makes self available to patients" (N = 15)

ABSTRACT (Eff. Pt. reporting on C.N. Acute)

"I was hallucinating at night. I was frightened to go to sleep. The charge nurse came over to me and told me to call her if there was anything to talk about, or to send for her, if I needed help. I slept better that night because of her offer."

ABSTRACT (Ineff. Pt. reporting on P.N. Acute)

"I thought I could turn to her for help but she just seemed to be engrossed in herself and in watching the television. I thought she ignored me completely and it seemed to me I was a nuisance to her."

| <u>Shift</u> (N = 15) | | <u>Specialty</u> (N = 15) | | | <u>Eff. Ineff.</u> (N = 15) | |
|-----------------------|-----|---------------------------|----------|-------|-----------------------------|--------|
| Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| 5 | 10 | 1 | 4 | 10 | 12 | 3 |

Staff reported on (N = 31)

| C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
|------------------------|-------|---------------------|-------|------|------|
| 6 | 6 | 6 | 8 | 5 | 0 |
| Patient respondents 11 | | Other respondents 4 | | | |

Incidents in this Sub-category came mainly from patients and related to five grades of staff. Although they were relatively few in number, a considerable degree of importance was attached to them by the respondents. It may be that this aspect of care "Makes self available to patients" is one which is not fully recognised by nurses as having the importance which patients clearly attach to it.

AREA A Category I Sub-category 2

"Provides opportunities, or encourages patients to talk about their problems" (N = 138)

ABSTRACT (Eff. Pt. reporting on C.N. Acute)

"One day when I felt really confused and depressed, I felt like killing myself. I told one of the nurses how I felt and she sat down with me and had a chat with me. It helped me greatly just being able to talk to someone about how I felt. The nurse really had helped me by just letting me talk."

ABSTRACT (Ineff. Pt. reporting on Sf.N. Acute)

"There was a time when I was depressed and inwardly crying out for someone to talk to. The staff nurse was not prepared to give up even one minute of her time to discuss my feelings. I know they all do a marvellous job but there are times when you need to talk."

| | <u>Shift</u> (N = 138) | | <u>Specialty</u> (N = 138) | | | <u>Eff. Ineff.</u> (N = 138) | |
|----|-------------------------|-----|----------------------------|----------|-------|------------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 33* | 105 | 28 | 35 | 75* | 115* | 23 |
| E. | 21 | 117 | 35 | 50 | 53 | 90 | 48 |
| | (x ² = 8.1S) | | (x ² = 15.0S) | | | (x ² = 19.9S) | |

| | <u>Staff reported on</u> (N = 183) | | | | | |
|----|------------------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 42 | 37* | 41* | 25* | 15 | 23 |
| E. | 46 | 26 | 34 | 24 | 17 | 36 |
| | (x ² = 11.4S) | | | | | |

Patient respondents 56 Other respondents 82

The x² showed the night shift, acute specialty and the effective incidents to dominate this Sub-category. The difference between grades was also significant, with the charge nurse being under-represented along with pupil nurses and nursing assistants.

A number of respondents, seeking to "explain" why they were occasionally unable to give time to patients to allow them to talk about their problems, suggested that "lack of staff" was the cause. A number of nurse respondents described the potential, or actual, serious consequences of failing to enable patients to "talk". For example, one nurse described how a patient who was not allowed to "talk" attempted to commit suicide.

AREA A Category I Sub-category 3

"Is warm, understanding and sympathetic towards patients.
Delivers care with sensitivity and demonstrates empathy"
(N = 317)

ABSTRACT (Eff. Pt. reporting on C.N. Acute)

"I was in a state of despair and depression. The charge nurse talked to me often and tried to get me to calm down. I felt that everyone was against me but her kindness and understanding made all the difference in the world. Knowing that she cared for me really made all the difference to me."

ABSTRACT (Ineff. Sf.N. reporting on C.N. Long St.)

"The charge nurse had slept in that morning, she came on duty in a bad mood. Her anger with herself was turned on the patients, she shouted at them and they became upset. The whole ward became disturbed, most of the patients became difficult to work with for the rest of the day."

| <u>Shift</u> (N = 317) | | <u>Specialty</u> (N = 317) | | | <u>Eff. Ineff.</u> (N = 317) | |
|------------------------|-----------------------------|----------------------------|-------------------------|----------|------------------------------|--------------------------|
| | Night | Day | Ger. | Long St. | Acute | Eff. Ineff. |
| O. | 45 | 272 | 61 | 112 | 144* | 168 149* |
| E. | 48 | 269 | 81 | 114 | 122 | 208 109 |
| | (X ² = 0.2 N.S.) | | (X ² = 8.9S) | | | (X ² = 22.4S) |

| <u>Staff reported on (N = 477)</u> | | | | | | |
|------------------------------------|-----------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 117 | 81 | 75 | 59 | 48 | 97 |
| E. | 120 | 69 | 89 | 61 | 44 | 94 |
| | (X ² = 4.9 N.S.) | | | | | |

Patient respondents 176. Other respondents 141.

The acute specialty was over-represented in this Sub-category, as were the ineffective incidents. The reason for the over-representation of ineffective incidents is not known, however it may be indicative of the high visibility nature of the activity when it is performed badly. Thus, care which is delivered with understanding, sympathy, sensitivity and empathy will attract less attention and comment than care which is lacking in these qualities. All groups of respondents described considerable anti-therapeutic results following, for example, harsh or unsympathetic treatment of patients.

AREA A Category I Sub-category 4

"Reassures patient. Encourages feeling of confidence, security or optimism" (N = 67)

ABSTRACT (Eff. C.N. reporting on St.N. Acute)

"A patient suffered from a fear of open spaces and of meeting people, she had not been out of her house for many months. The

nurse accompanied the patient on outings to shops, giving her support and confidence. The presence of the nurse gave the patient the confidence she required to cope with meeting people."

ABSTRACT (Ineff. Pt. reporting on Sf.N. Long St.)

"I came into hospital very ill. I accidentally touched the locker door with my foot and was immediately put to bed and was given a painful injection. I lost confidence in the hospital and the staff after that."

| | <u>Shift</u> (N = 67) | | <u>Specialty</u> (N = 67) | | | <u>Eff. Ineff.</u> (N = 67) | |
|----|-----------------------------|-----|---------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 9 | 58 | 9 | 23 | 35* | 57* | 10 |
| E. | 10 | 57 | 17 | 24 | 26 | 44 | 23 |
| | (x ² = 0.1 N.S.) | | (x ² = 6.9S) | | | (x ² = 11.2S) | |

| <u>Staff reported on (N = 107)</u> | | | | | | |
|------------------------------------|-----------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 22 | 22 | 18 | 16 | 11 | 18 |
| E. | 27 | 15 | 20 | 14 | 10 | 21 |
| | (x ² = 5.2 N.S.) | | | | | |

Patient respondents 43 Other respondents 24

Patient responses in this Sub-category were greater than those of staff by a ratio of almost 2 to 1, and the great majority of incidents were of the effective type. As with incidents relating to "Makes self available to patients" it may be that this aspect of care is more clearly recognised by patients than by staff. Patient respondents frequently used the terms "reassurance", "confidence", "security" and "optimism" when describing the activity of the nurse, they appeared to use these terms with much enthusiasm. All staff grades were reported on with the x² detecting no significant differences between grades.

AREA A Category I Sub-category 5

"Plans or encourages specific one-to-one nurse-patient relationships" (N = 75)

ABSTRACT (Eff. St.N. reporting on Self. Acute)

"The patient was admitted with a diagnosis of depression. She could not make friends or form meaningful relationships with people. I started to make definite attempts to break down the nurse-patient barrier between us. I made it obvious to her that I wanted to form a special relationship. Within the limits of professional conduct I confided in the patient my own feelings, weaknesses and so on. This genuine attempt to gain her trust, respect and affection paid off after some time. A meaningful relationship was formed, proving to the patient that this was possible."

ABSTRACT (Ineff. C.N. reporting on Self. Acute)

"The patient was rather demanding and unco-operative with staff and other patients. I was harsh and unduly authoratative with this patient. My approach was completely wrong, it destroyed any chance of me forming a successful rapport with him and developing a useful therapeutic relationship."

| | <u>Shift</u> (N = 75) | | <u>Specialty</u> (N = 75) | | | <u>Eff. Ineff.</u> (N = 75) | |
|----|-----------------------------|-----|-----------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 9 | 66 | 16 | 24 | 35 | 65* | 10 |
| E. | 11 | 64 | 19 | 27 | 29 | 49 | 26 |
| | (X ² = 0.4 N.S.) | | (X ² = 2.0 N.S.) | | | (X ² = 15.1S) | |

| <u>Staff reported on (N = 80)</u> | | | | | | |
|-----------------------------------|-----------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 21 | 10 | 14 | 15 | 6 | 14 |
| E. | 20 | 12 | 15 | 10 | 7 | 16 |
| | (X ² = 3.3 N.S.) | | | | | |

Patient respondents 14 Other respondents 61

All staff grades were involved in this activity, the only significant X² result being in relation to Eff./Ineff. incidents with the effective incidents being more numerous than expected.

This significant X^2 may not be surprising in view of the high visibility nature of the formation of specific one-to-one nurse patient relationships. In short, if they occur they are noticed, if not, their absence is less obvious and attracts less comment. This may also suggest that the formation of such relationships is not seen as an expected or important part of the psychiatric nurses' role. Alternatively, it may be that their existence is positive and therapeutic, their non-existence is not seen as negative or anti-therapeutic.

AREA A Category I Sub-category 6

"Recognises and encourages patients' individuality. Emphasises worth of patient and maximises level of self esteem" (N = 64)

ABSTRACT (Eff. E.N. reporting on Self. Acute)

"The patient was very anxious about her husband's coming visit to her. She was worried about the way she was looking, her hair was untidy and she hadn't washed for some days. I suggested that the patient have a bath and wash her hair. I gave her a nice hair-do, it made her feel really smart and less worried about the visit."

ABSTRACT (Ineff. C.N. reporting on E.N. Long St.)

"A patient had been changed into smart suit because he was having visitors. When the visitors had gone the nurse changed him back into a pair of dirty and stained trousers. The patient was very upset about his untidy appearance and felt he was being discouraged from taking an interest in his appearance."

| | <u>Shift</u> (N = 64) | | <u>Specialty</u> (N = 64) | | | <u>Eff. Ineff.</u> (N = 64) | |
|----|-------------------------|-----|-----------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 4 | 60* | 12 | 20 | 32 | 47 | 17 |
| E. | 10 | 54 | 16 | 23 | 25 | 42 | 22 |
| | (X ² = 4.3S) | | (X ² = 3.3 N.S.) | | | (X ² = 1.7 N.S.) | |

| Staff reported on (N = 94) | | | | | | |
|-----------------------------|------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 18 | 13 | 17 | 13 | 10 | 23 |
| E. | 24 | 13 | 17 | 12 | 9 | 19 |
| (x ² = 2.3 N.S.) | | | | | | |

Patient respondents 22 Other respondents 42

There was no significant difference between grades reported on in this Sub-category. Almost all incidents related to day shift activity, this may reflect the limited opportunity for this type of activity to take place at night time. A number of the ineffective incidents came from patient respondents and included examples of personal humiliation and failure by nurses to recognise patients' personal individuality.

AREA A Category I Sub-category 7

"Encourages or provides social stimulation. Exposes patient to institutional or non-institutional social experiences"
(N = 355)

ABSTRACT (Eff. C.N. reporting on P.N. Ger.)

"The patients were sitting around the ward all day, most were asleep. The nurse got a ball and threw it to each patient in turn. The patients became more alert and responsive."

ABSTRACT (Ineff. Pt. reporting on C.N. Long St.)

"All during the winter I enjoyed the whist and bingo sessions. The nurse stopped these sessions for the duration of the summer months. This deprived the patients of a great deal of pleasure and recreation."

| <u>Shift</u> (N = 355) | | <u>Specialty</u> (N = 355) | | | <u>Eff. Ineff.</u> (N = 355) | |
|-----------------------------|-------|----------------------------|------|----------|------------------------------|-------------|
| | Night | Day | Ger. | Long St. | Acute | Eff. Ineff. |
| O. | 48 | 307 | 143* | 157* | 55 | 335* 20 |
| E. | 54 | 301 | 91 | 128 | 136 | 233 122 |
| (x ² = 0.8 N.S.) | | (x ² = 84.5S) | | | (x ² = 129S) | |

| Staff reported on (N = 425) | | | | | | |
|-----------------------------|------|-----------------------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 97 | 40 | 78 | 52 | 42* | 116* |
| E. | 107 | 61 | 79 | 55 | 39 | 84 |
| (X ² = 20.8S) | | | | | | |
| Patient respondents | 40 | Other respondents 315 | | | | |

The vast majority of incidents, 89%, came from non-patient respondents, related mainly to day shift, were effective with pupil nurses and nursing assistants being over-represented. The specialty emphasis, not surprisingly, was on the two long term areas of care, suggesting a high level of importance for this type of care being made available to patients who spend longer, rather than shorter, periods in hospital.

The incidents provided by patients related to the social stimulation satisfying the needs of individual patients. Conversely, incidents from non-patient respondents generally related to providing stimulation to satisfy the needs of patient groups. For example "all the patients in the sitting room", or "a group of patients with nothing to do".

AREA A Category I Sub-category 8

"Minimises patients' communication difficulties" (N = 21)

ABSTRACT (Eff. Sf.N. reporting on Sf.N. Ger.)

"An old man wanted to go to the toilet and none of the nurses could understand what he was saying. The nurse sat beside him for ten minutes until she understood what the patient wanted."

ABSTRACT (Ineff. E.N. reporting on P.N. Long St.)

"This particular patient had great difficulty in communicating but could do so if given time. He spoke to a nurse who, because she couldn't understand, ignored him. The patient became frustrated and began to pack his cases to leave the ward. If the nurse couldn't understand the patient, she should have made more effort to do so or referred the matter to a nurse who could understand him."

| <u>Shift</u> (N = 21) | | <u>Specialty</u> (N = 21) | | | <u>Eff. Ineff.</u> (N = 21) | |
|-----------------------|-----|---------------------------|----------|-------|-----------------------------|--------|
| Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| 3 | 18 | 11 | 5 | 5 | 13 | 8 |

Staff reported on (N = 21)

| C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
|---------------------|-------|------|-------------------|------|------|
| 4 | 2 | 3 | 2 | 4 | 6 |
| Patient respondents | | 1 | Other respondents | | 20 |

Despite the relatively small number of incidents in this Sub-category, involving both shifts, all specialties and all grades reported on, much importance was attached to it in terms of the actual or potential seriousness of its consequences. Considering the high level of communication difficulty which is known to exist in psychiatric hospitals, particularly among long term patients, it is surprising that this Sub-category was not more frequently mentioned.

AREA A Category I Sub-category 9

"Recognises personal limitations when using self as a therapeutic tool" (N = 12)

ABSTRACT (Ineff. Dr. reporting on St.N. Acute)

"A difficult, demanding and attention seeking patient was admitted to the ward. The student nurse became over-involved with the patient and allowed herself to be manipulated by him. The nurse had failed to recognise her own limitations and lack of experience."

| <u>Shift</u> (N = 12) | | <u>Specialty</u> (N = 12) | | | <u>Eff. Ineff.</u> (N = 12) | |
|-----------------------|-----|---------------------------|----------|-------|-----------------------------|--------|
| Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| 0 | 12 | 1 | 3 | 8 | 0 | 12 |

Staff reported on (N = 12)

| C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
|---------------------|-------|------|-------------------|------|------|
| - | - | 1 | 9 | - | 2 |
| Patient respondents | | 0 | Other respondents | | 12 |

All reported incidents were ineffective, perhaps effective examples were never noticed. This possible lack of recognition of the nurse who does recognise personal limitations in relation to patient care may conceivably discourage inexperienced nurses from doing so, and may result in its importance not being taught.

AREA A Category I Sub-category 10

"Gives patient explanation of treatment, nursing care or nursing decisions" (N = 82)

ABSTRACT (Eff. N.A. reporting on Sf.N. Acute)

"The patient was developing a pressure sore. As well as treating the patient, the nurse explained the object of the treatment and the function of each ointment used. This helped the patient to understand what was being done and encouraged her to maximise the effect of the treatment."

ABSTRACT (Ineff. E.N. reporting on P.N. Ger.)

"A patient had to be taken in a wheelchair to the bathroom. The nurse just went to the patient and moved her without warning or telling her she was to have a bath. The patient became upset at being suddenly moved and bathed without explanation."

| | <u>Shift</u> (N = 82) | | <u>Specialty</u> (N = 82) | | | <u>Eff. Ineff.</u> (N = 82) | |
|----|-----------------------------|-----|---------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 11 | 71 | 26* | 19 | 37* | 45 | 37* |
| E. | 12 | 70 | 21 | 30 | 31 | 54 | 28 |
| | (x ² = 0.1 N.S.) | | (x ² = 6.4S) | | | (x ² = 4.4S) | |

| <u>Staff reported on (N = 92)</u> | | | | | | |
|-----------------------------------|-----------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 25 | 12 | 20 | 6 | 12 | 17 |
| E. | 23 | 13 | 17 | 12 | 9 | 18 |
| | (x ² = 4.8 N.S.) | | | | | |

Patient respondents 18 Other respondents 64

The significant x² in relation to specialties may reflect the acute nature of the illness experienced by patients in the geriatric

and acute specialties, in which the observed number exceeded the expected. In short, patients in these two areas may require more explanation, by virtue of the acute nature of their illness, than patients in long stay wards.

The χ^2 relating to effective/ineffective incidents indicated an over-representation of ineffective incidents, which may be particularly unacceptable in a profession which places so much importance on giving patients an explanation on nursing care and treatment generally.

AREA A Category I Sub-category 11

"Identifies patients intellectual, spiritual, emotional or social needs or limitations" (N = 26)

ABSTRACT (Ineff. C.N. reporting on Self. Long St.)

"A patient asked if he could go and look for work outside the hospital. I encouraged the patient to look for work without taking full account of the patients ability to look for it or, if he found a job, his ability to undertake employment. I failed to take account of the limitations of this particular patient."

| <u>Shift</u> (N = 26) | | | <u>Specialty</u> (N = 26) | | | <u>Eff. Ineff.</u> (N = 26) | |
|-------------------------------|-------|-----|---------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 2 | 24 | 5 | 10 | 11 | 7 | 19* |
| E. | - | - | 7 | 9 | 10 | 17 | 9 |
| $(\chi^2 = 0.8 \text{ N.S.})$ | | | | | | $(\chi^2 = 16S)$ | |

Staff reported on (N = 26)

| C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
|---------------------|-------|------|-------------------|------|------|
| 13 | 5 | 2 | 3 | 1 | 2 |
| Patient respondents | | 9 | Other respondents | | 17 |

The only significant χ^2 related to the effective/ineffective distribution, 73% of these being ineffective. This may be a further example of a behaviour which is only readily noticed if it is badly done.

AREA A Category I Sub-category 12

"Encourages patient to accept treatment or nursing care" (N = 114)

ABSTRACT (Eff. C.N. reporting on Self. Acute)

"A patient suddenly decided to leave hospital. I persuaded him to stop and talk about his decision to leave, and suggested he should stay and accept the treatment offered him. My persuasion was successful, resulting in the patient becoming more settled and willing to stay in hospital."

ABSTRACT (Ineff. St.N. reporting on N.A. Ger.)

"An alcoholic patient was very strong willed but could be persuaded to do things if approached in the right way. The nurse approached the patient and, instead of coaxing her, said "Right, bed-time, come on", the patient refused and became difficult."

| | <u>Shift</u> (N = 114) | | <u>Specialty</u> (N = 114) | | | <u>Eff. Ineff.</u> (N = 114) | |
|----|----------------------------|-----|-----------------------------|----------|-------|------------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 18 | 96 | 29 | 44 | 41 | 75 | 39 |
| E. | 17 | 97 | 29 | 41 | 44 | 74 | 40 |
| | (X ² = .1 N.S.) | | (X ² = 0.4 N.S.) | | | (X ² = 0 N.S.) | |

| <u>Staff reported on (N = 124)</u> | | | | | | |
|------------------------------------|-----------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 34 | 14 | 33 | 13 | 8 | 22 |
| E. | 31 | 19 | 23 | 16 | 11 | 24 |
| | (X ² = 7.5 N.S.) | | | | | |

Patient respondents 13 Other respondents 101

None of the X² were significant in this Sub-category, both shifts, all specialties and all staff grades being included. A number of the ineffective incidents described situations which clearly resulted in non-acceptance of treatment by patients, for example patients leaving hospital or refusing to take medication, while a number of effective incidents resulted in acceptance of treatment.

AREA A Category I Sub-category 13

"Maximises staff-patient trust" (N = 48)

ABSTRACT (Eff. Sf.N. reporting on Self. Acute)

"The patient suffered from a paranoid type illness and would not trust anyone. I told the patient the truth about his illness, the type of treatment he would receive, and the possible results of the treatment. He had been so used to being tricked into acceptance of treatments that he expressed surprise at my honesty, we developed a trusting relationship."

ABSTRACT (Ineff. N.A. reporting on E.N. Long St.)

"A patient was very frightened and confused. The nurse promised to take the patient for a walk and this seemed to pacify the patient. The nurse did not take her for a walk, resulting in even more confusion and disturbance, the patient started shouting at all the staff, calling them liars and cheats."

| <u>Shift</u> (N = 48) | | | <u>Specialty</u> (N = 48) | | | <u>Eff. Ineff.</u> (N = 48) | |
|-----------------------|-----------------------------|-----|---------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 10 | 38 | 5 | 13 | 30* | 13 | 35* |
| E. | 7 | 41 | 12 | 17 | 19 | 31 | 17 |
| | (x ² = 1.5 N.S.) | | (x ² = 11.4S) | | | (x ² = 29.5S) | |

Staff reported on (N = 58)

| C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
|---------------------|-------|------|-------------------|------|------|
| 15 | 11 | 14 | 6 | 6 | 6 |
| Patient respondents | | 17 | Other respondents | | 31 |

All staff grades in both shifts featured as often as was expected in this Sub-category the acute specialty being over-represented. The x² relating to effective/ineffective demonstrated that ineffective incidents far outweighed the effective incidents. This x² result may reflect the low recognition given to this behaviour. In short, if nurse-patient trust is fostered, it is hardly noticed, if trust is diminished, then the resulting difficulties draw it to attention.

AREA A Category I Sub-category 14

"Chooses appropriate nursing care" (N = 133)

ABSTRACT (Eff. St.N. reporting on C.N. Long St.)

"A patient had become upset because her friend had been shifted to another dinner table, she also wanted to change tables. That night she threatened to smash up crockery and bottles.

The nurse took her aside and spoke to her, trying to sort out her problems. The patient was moved into an observation dormitory and given lots of jobs to do around the ward.

This was effective because the charge nurse had tackled the problem in the best possible way and not allowed the situation to get out of hand."

ABSTRACT (Ineff. Sf.N. reporting on Sf.N. Ger.)

"A confused old man was refusing to take his medication, he refused and rejected any approach the nurse made. Instead of asking someone else to offer the patient his medication, the nurse tried harder to persuade the old man. When the staff nurse saw that his approach was not working, he should have used an alternative one."

| <u>Shift</u> (N = 1-3) | | | <u>Specialty</u> (N = 133) | | | <u>Eff. Ineff.</u> (N = 133) | |
|------------------------|-----------------------------|-----|-----------------------------|----------|-------|------------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 25 | 108 | 29 | 58 | 46 | 23 | 110* |
| E. | 20 | 113 | 34 | 48 | 51 | 87 | 46 |
| | (X ² = 1.5 N.S.) | | (X ² = 3.3 N.S.) | | | (X ² = 136S) | |

Staff reported on (N = 158)

| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
|----|------|-------|------|-------|------|------|
| O. | 53 | 22 | 32 | 16 | 8 | 27 |
| E. | 40 | 23 | 29 | 20 | 15 | 31 |

(X² = 9.2 N.S.)

Patient respondents 20 Other respondents 113

Behaviour placed in this Sub-category applied to both shifts, all three specialties and all staff grades, the X² detecting no significant differences in relation to these.

The only significant χ^2 related to the larger than expected number of incidents which were ineffective (83% of the total). Thus, poor or inappropriate performance may attract attention more readily than does the choice of appropriate nursing care.

AREA A Category I Sub-category 15

"Presents self as a role model to patients" (N = 1)

ABSTRACT (Eff. Sf.N. reporting on Self. Long St.)

"A psychopathic patient stated that he was too much of a 'hard man' to attend social functions in the hospital. I accompanied the patient to a number of social functions and demonstrated to him that attendance was not a sign of being a 'weakling'. The patient began to model himself on me, enjoying the social functions more and more."

| <u>Shift</u> (N = 1) | | <u>Specialty</u> (N = 1) | | | <u>Eff. Ineff.</u> (N = 1) | |
|----------------------|-----|--------------------------|----------|-------|----------------------------|--------|
| Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| - | 0 | - | 1 | - | 1 | - |

| <u>Staff reported on</u> (N = 1) | | | | | |
|----------------------------------|-------|------|-------|------|------|
| C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| - | 1 | - | - | - | - |

| | | | |
|---------------------|---|-------------------|---|
| Patient respondents | 0 | Other respondents | 1 |
|---------------------|---|-------------------|---|

The importance of this incident, relating as it does to a nurse role which is frequently referred to in the text-books, is the infrequency with which it was described.

AREA A Category I Sub-category 16

"Is consistent in delivery of care" (N = 29)

ABSTRACT (Eff. P.N. reporting on Self. Acute)

"It is important to have the same nurses working on the ward all the time. The patients and staff get to know each other and there aren't too many changes in the ward policies or type of care given."

ABSTRACT (Ineff. St.N. reporting on C.N. Acute)

"The patients were getting up in the morning and going for breakfast. The charge nurse said that one patient, her "favourite", could have a long lie and breakfast in bed. This special treatment caused ill feeling between the patients and between the staff and patients."

| Shift (N = 29) | | | Specialty (N = 29) | | | Eff. Ineff. (N = 29) | |
|-----------------------------|-------|-----|--------------------|----------|-------|--------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 5 | 24 | 7 | 13 | 9 | 6 | 23* |
| E. | - | - | 8 | 10 | 11 | 19 | 10 |
| (x ² = 0.4 N.S.) | | | | | | (x ² = 25.8S) | |

| Staff reported on (N = 38) | | | | | |
|----------------------------|-------|------|-------------------|------|------|
| C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| 16 | 2 | 4 | 4 | 3 | 9 |
| Patient respondents | | 3 | Other respondents | | 26 |

The only significant x² indicating the preponderance of ineffective incidents, may yet again reflect that some behaviours are only noticed when they are done badly, or not done at all.

Summary of distribution of incidents within AREA A "STAFF INITIATED INTERVENTION", Category I "Uses Self As A Therapeutic Tool", Sub-categories 1 - 16

Shift

For Category I as a whole a significant majority of incidents related to day shift, however this did not hold true for all 16 Sub-categories. Ten Sub-categories were subjected to the x², the results being as follows;

No significant differences between shift; 8 Sub-categories
Day shift over-represented ; 1 Sub-category
Night shift over-represented ; 1 Sub-category

It could be argued that, in relation to "Uses Self As A Therapeutic Tool", differences between shifts are minimal. Indeed the fact that, with two exceptions, all Sub-categories contained incidents relating to night and day shift, suggests that

skills in this area are a requirement for nurses working on both day shift and night shift.

Specialty

In Category I, the specialty "emphasis" was in the acute and long stay specialties. However, the twelve X^2 tests which were done suggested that all three specialties were over-represented in one or more of the Sub-categories. The X^2 results were as follows;

| | |
|--|--------------------|
| No significant difference between specialties; | 6 Sub-categories |
| Geriatric specialty over-represented | ; 2 Sub-categories |
| Long-stay specialty over-represented | ; 1 Sub-category |
| Acute specialty over-represented | ; 5 Sub-categories |

The Sub-categories which were over-represented in relation to the geriatric specialty were;

Sub-category 7 "Encourages or provides social stimulation. Exposes patient to institutional or non-institutional social experiences."

Sub-category 10 "Gives patient explanation of treatment, nursing care or nursing decisions."

Both of the above items may well be directly related to the nature of the illness experienced by the patient in the geriatric specialty. First, the long term nature of their hospitalisation, and their difficulty in generating and sustaining social interaction requires that others (nurses) assist. Second, short term memory deterioration is frequently experienced by the patient in the geriatric specialty, resulting in the need for relatively more frequent explanation relating to treatment, and nursing care.

Sub-category 7 (see above) was the only one which was over-represented in the long stay specialty. Again, the long term nature of the care in this specialty may account for the emphasis on social stimulation and experiences.

The Sub-categories which were over-represented in the acute specialty were:

Sub-category 2 "Provides opportunities or encourages patients to talk about their problems."

Sub-category 3 "Is warm, understanding and sympathetic towards patients. Delivers care with sensitivity and demonstrates empathy."

Sub-category 4 "Reassures patient. Encourages feeling of confidence, security or optimism."

Sub-category 10 "Gives patients explanation of treatment, nursing care or nursing decisions."

Sub-category 13 "Maximises staff-patient trust."

That five of the sixteen Sub-categories were over-represented in the acute specialty may be indicative of nursing skills in this area of care emphasising the use of self as a therapeutic tool. Collectively, the five Sub-categories described above do constitute an important element of the psycho-therapeutic process. It may be that while these Sub-categories are not specialty specific, they constitute a relatively greater part of the role of the nurse caring for patients in the acute specialty.

Thus, in relation to "Uses Self As A Therapeutic Tool", nurses in all specialties were reported as using this skill. While the emphasis in six Sub-categories was on one or other of the specialties, all specialties were represented in 15 of the 16 Sub-categories.

Effective-Ineffective Incidents

At Category level, effective incidents were significantly over-represented according to the χ^2 test ($\chi^2 = 20.1$). The same was not so at Sub-category level with the χ^2 showing the following results on the occasions when the χ^2 , was applied;

No significant Eff-Ineff emphasis ; 3 Sub-categories
Effective incidents over-represented; 4 Sub-categories
Ineffective incidents over-
represented ; 6 Sub-categories

The Sub-categories where ineffective incidents significantly outnumbered effective incidents occurred more frequently than did those with no significant difference and the number where effective incidents dominated.

The Sub-categories in which ineffective incidents were over-represented tended to be of the type where inaction or ineffective function resulted in high visibility and potentially serious problems arising. For example in relation to Sub-category 3

"Is warm, understanding and sympathetic towards patients.
Delivers care with sensitivity and demonstrates empathy"

and

Sub-category 14 "Chooses appropriate nursing care"

The over-representation of ineffective incidents may indicate that nurses function poorly in these two areas, or that the activity is more readily noticed when it is performed badly.

Conversely, the Sub-categories in which the effective incidents were over-represented may have been performed well, alternatively they may have failed to attract attention when done badly or not at all. Examples of such Sub-categories are;

Sub-category 2 "Provides opportunities, or encourages patients to talk about their problems."

Sub-category 4 "Reassures patient. Encourages feeling of confidence, security or optimism."

Staff reported on

At Category level, no significant difference between grades was detected. The χ^2 was applied to nine Sub-categories with no significant difference being detected in relation to seven of these. The χ^2 detected a significant difference in the distribution between grades in the following two Sub-categories;

Sub-category 2 "Provides opportunities, or encourages patients to talk about their problems."

Although the staff nurse, enrolled nurse and student nurse were over-represented in this Sub-category, the other three grades were also reported on relatively frequently. It is interesting to note that the most experienced grade of staff, the charge nurse, was under-represented while the student nurse, a relatively inexperienced staff member, was over-represented.

The χ^2 also detected a significant difference in the distribution of incidents between grades in relation to

Sub-category 7 "Encourages or provides social stimulation. Exposes patient to institutional or non-institutional social experiences."

The pupil nurse and nursing assistant grades were over-represented in this Sub-category, although all other four grades

were also reported on. This part of the role of the psychiatric nurse may be viewed as requiring less theoretical background than other role elements.

The general conclusion which may be drawn from the analysis of distribution of incidents is that the differences between grades were minimal.

AREA A Category II "Makes Therapeutic Use Of Environment" (N = 860)

ABSTRACT (Eff. Pt. reporting on all staff. Acute)

"After breakfast each morning, volunteer patients are asked by the nurses to sweep the corridor and wash the floor. This is effective because it helps us to get involved in the work of the ward, and it gives us something to do."

ABSTRACT (Ineff. E.N. reporting on E.N. Ger.)

"A patient was recently admitted to our ward, he was frightened by the strange surroundings. The nurse did not take time to show the patient around the ward or introduce him to other patients."

| <u>Shift</u> (N = 860) | | | <u>Specialty</u> (N = 860) | | | <u>Eff. Ineff.</u> (N = 860) | |
|------------------------|--------------------------|-----|----------------------------|----------|-------|------------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 183* | 677 | 369* | 280 | 211 | 457 | 403 |
| E. | 153 | 707 | 279 | 302 | 279 | 515 | 345 |
| | (x ² = 7.15S) | | (x ² = 47.2S) | | | (x ² = 16.3) | |

| | <u>Staff reported on (N = 1075)</u> | | | | | |
|----|-------------------------------------|-------|------|-------------------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 244 | 137 | 218* | 118 | 85 | 273* |
| E. | 275 | 147 | 211 | 131 | 88 | 223 |
| | (X ² = 17.0S) | | | | | |
| | Patient respondents | | 69 | Other respondents | | 791 |

Both shifts were represented in this category, although a greater than expected number of incidents related to night shift. The shift emphasis does not hold good for all Sub-categories, indeed the reverse is true in relation to the largest Sub-category (Sub-category 2).

The specialty emphasis was on the geriatric specialty although this did not hold true throughout.

The X² demonstrated an over-representation of ineffective incidents at Category level, but for both effective and ineffective incidents at Sub-category level.

Enrolled nurses and nursing assistants were the two over-represented grades in relation to distribution of incidents between staff grades.

AREA A Category II Sub-category 1

"Encourages patient-patient understanding and relationship"

(N = 19)

ABSTRACT (Eff. C.N. reporting on self. Ger.)

"An elderly confused patient was recently admitted to the ward. I introduced him to another patient whose only friend, another patient, had recently died. The two became good friends and seemed to enjoy each other's company."

ABSTRACT (Ineff. St.N. reporting on C.N. Ineff.)

"A patient had been rejected from the occupational therapy department because he could not get on with other patients. The charge nurse arranged for the patient to continue with his occupational therapy in a side room of the ward. This was wrong because it did not give the patient the opportunity to learn how

to develop relationships with other patients."

| <u>Shift</u> (N = 19) | | | <u>Specialty</u> (N = 19) | | | <u>Eff. Ineff.</u> (N = 19) | |
|-----------------------|-------|-----|-----------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 6 | 13 | 8 | 4 | 7 | 16* | 3 |
| E. | - | - | 8 | 6 | 5 | 10 | 9 |
| | | | (X ² = 1.5 N.S.) | | | (X ² = 7.6S) | |

Staff reported on (N = 19)

| C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
|---------------------|-------|------|-------------------|------|------|
| 6 | 3 | 3 | 3 | 1 | 3 |
| Patient respondents | | 2 | Other respondents | | 17 |

The only significant X² demonstrated an over-representation of effective incidents, this may be indicative of the activity, if done, being seen as positive and therapeutic, its absence being less easily noticed.

AREA A Category II Sub-category 2

"Encourages or facilitates patient playing an active part in treatment or self care. Encourages independence." (N = 422)

ABSTRACT (Eff. N.A. reporting on Sf.N. Ger.)

"A patient was feeling bored with nothing to do in the ward. The nurse allowed the patients to help around the ward, setting tables and so on. This made the patient feel useful and more independent."

ABSTRACT (Ineff. N.A. reporting on C.N. Ger.)

"The charge nurse told me to dress a particular patient by 7.30 a.m. The patient began to fight and kick when I started to dress her. Later, I discovered that the patient was perfectly able to dress herself, that was probably the cause of her resistance."

| Shift (N = 422) | | | Specialty (N = 422) | | | Eff. Ineff. (N = 422) | |
|-----------------|--------------------------|------|--------------------------|----------|-------|-------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 61 | 361* | 188* | 159* | 75 | 251* | 171 |
| E. | 90 | 332 | 181 | 137 | 104 | 225 | 197 |
| | (x ² = 11.9S) | | (x ² = 11.9S) | | | (x ² = 6.4S) | |

| Staff reported on (N = 542) | | | | | | |
|-----------------------------|-----------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 118 | 69 | 105 | 63 | 46 | 141 |
| E. | 123 | 69 | 110 | 59 | 43 | 138 |
| | (x ² = 1.0 N.S.) | | | | | |

Patient respondents 19 Other respondents 403

The dominant shift, day shift, may reflect increased opportunity for this activity. The long stay and geriatric specialties were also over-represented, while the acute specialty was significantly under-represented with 18% of the incidents.

The emphasis was on effective incidents, although on substantial proportion (40%) of the incidents were ineffective.

All staff grades were reported on with the x² showing no significant difference between grades.

AREA A Category II Sub-category 3

"Maximises patients' privacy." (N = 14)

ABSTRACT (Eff. Sf.N. reporting on Self. Ger.)

"An elderly patient required to use the toilet but was unable to use a commode or bed-pan. I helped her to the toilet which was best for her because she was very fussy about privacy."

ABSTRACT (Ineff. St.N. reporting on N.A. Acute)

"Two patients had been incontinent and the nurse decided to change them in the sitting room. She proceeded to change the patients in full view of everyone else in the room. This stripped the patients of their dignity."

| <u>Shift</u> (N = 14) | | <u>Specialty</u> (N = 14) | | | <u>Eff. Ineff.</u> (N = 14) | |
|-------------------------|-----|---------------------------|----------|-------|-----------------------------|--------|
| Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| 4 | 10 | 4 | 2 | 8 | 3 | 11* |
| - | - | - | - | - | 7 | 7 |
| (X ² = 4.6S) | | | | | | |

| <u>Staff reported on</u> (N = 14) | | | | | |
|-----------------------------------|-------|------|-------------------|------|------|
| C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| 2 | 4 | 2 | 2 | 1 | 3 |
| Patient respondents | | 3 | Other respondents | | 11 |

The only X² applied to incidents in this Sub-category showed a significant proportion of the incidents to relate to ineffective activity. All grades, both shifts and all three specialties were included.

AREA A Category II Sub-category 4

"Individualises patient care. Adapts the environment, routine or care to suit individual patients." (N = 257)

ABSTRACT (Eff. Sf.N. reporting on St.N. Acute)

"A confused patient was taken to the dining room for her meal but she was overcome by the crowd. She began to shout and upset the other patients. The nurse took the patient in to a quiet sitting room to complete her meal. This was effective because the special arrangement enabled the patient to enjoy her meal without upsetting others."

ABSTRACT (Ineff. Pt. reporting on Sf.N. Long Stay)

"I wanted to telephone my sister but the nurse would not let me. He refused to let me go to the phone because it was after dark. This upset me a great deal because it was important that I talk to my sister."

| <u>Shift</u> (N = 257) | | | <u>Specialty</u> (N = 257) | | | <u>Eff. Ineff.</u> (N = 257) | |
|------------------------|---------------------------|-----|----------------------------|----------|-------|------------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 76* | 181 | 132* | 76 | 49 | 105 | 152* |
| E. | 55 | 202 | 110 | 84 | 63 | 137 | 120 |
| | (x ² = 10.25S) | | (x ² = 8.3S) | | | (x ² = 16.0S) | |

| <u>Staff reported on</u> (N = 327) | | | | | | |
|------------------------------------|-----------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 77 | 35 | 73 | 26 | 26 | 90 |
| E. | 74 | 42 | 66 | 36 | 26 | 83 |
| | (x ² = 5.4 N.S.) | | | | | |

Patient respondents 24 Other respondents 233

The x² test detected an emphasis on night shift, geriatric specialty and ineffective incidents in this Sub-category, with all staff grades being reported on.

The emphasis on ineffective, night shift and geriatric specialty may be indicative of areas of care where nursing tends to become less individualised and more routinised.

AREA A Category II Sub-category 5

"Introduces patient to ward rules, geography, staff or other patients." (N = 34)

ABSTRACT (Eff. C.N. reporting on St.N. Acute)

"A patient was being admitted to the ward, it was his first time in hospital. The patient was introduced to other patients, shown his bed, then given a tour of the ward. This was helpful because it made the patient feel welcome and settle quickly into the ward."

ABSTRACT (Ineff. Pt. reporting on all staff. Acute)

"I was admitted to the ward and the nurse took note of my name, age and so on. None of the ward staff told me what rules and regulations were. This meant that each time I wanted to know something I had to disturb the staff and ask. With one admission per day to the ward, staff are going to be constantly interrupted by patients seeking information they could easily be

given on admission."

| <u>Shift</u> (N = 34) | | <u>Specialty</u> (N = 34) | | | <u>Eff. Ineff.</u> (N = 34) | |
|-----------------------|-----------------------------|---------------------------|--------------------------|----------|-----------------------------|-------------------------|
| | Night | Day | Ger. | Long St. | Acute | Eff. Ineff. |
| O. | 4 | 30 | 5 | 7 | 22* | 25* 9 |
| E. | 7 | 27 | 15 | 11 | 8 | 18 16 |
| | (x ² = 1.6 N.S.) | | (x ² = 32.6S) | | | (x ² = 5.8S) |

| <u>Staff reported on</u> (N = 39) | | | | | |
|-----------------------------------|-------|------|-------------------|------|------|
| C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| 10 | 7 | 7 | 7 | 2 | 6 |
| Patient respondents | | 11 | Other respondents | | 23 |

Effective and acute specialty incidents occurred more frequently than expected. The specialty emphasis may be due to the much higher rate of admission to the acute type of ward, and therefore the greater need for introductions.

AREA A Category II Sub-category 6

"Observes or supervises patients." (N = 80)

ABSTRACT (Eff. C.N. reporting on self. Acute)

"A patient became rather confused after having a bath. I summoned medical assistance and put the patient to bed. This was effective because, due to close observation of the patient, I was able to detect a change and act accordingly."

ABSTRACT (Ineff. Sf.N. reporting on E.N. Acute)

"An enrolled nurse was asked to supervise the patients in the lounge, she was given a pupil nurse to assist her. The enrolled nurse left the lounge to take care of some job elsewhere in the ward, leaving the patients inadequately supervised. One patient fell, another left the building and got "lost" in the grounds. The enrolled nurse just did not see the importance of proper patient observation."

| Shift (N = 80) | | | Specialty (N = 80) | | | Eff. Ineff. (N = 80) | |
|----------------|---------------------------|-----|-----------------------------|----------|-------|--------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 30* | 50 | 31 | 21 | 28 | 27 | 53* |
| E. | 17 | 63 | 34 | 26 | 20 | 43 | 37 |
| | (X ² = 12.65S) | | (X ² = 4.4 N.S.) | | | (X ² = 12.8S) | |

| Staff reported on (N = 85) | | | | | | |
|----------------------------|-----------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 14 | 13 | 16 | 11 | 6 | 25 |
| E. | 19 | 11 | 17 | 9 | 7 | 22 |
| | (X ² = 2.7 N.S.) | | | | | |

Patient respondents 3 Other respondents 77

No significant differences between grades were detected by the X², or between specialties. The night emphasis for shift may reflect the importance of this activity for night staff. The ineffective emphasis may reflect the poor quality of nursing skill in this area of care or that the activity is much more easily noticed when it is badly done.

AREA A Category II Sub-category 7

"Makes therapeutic use of staff-patient or patient-patient groups." (N = 34)

ABSTRACT (Eff. C.N. reporting on self. Long St.)

"Patients were sitting around the ward and were inclined to be aggressive towards each other. I talked to each patient and got them to form a group for discussion, games and so on. They became more interested in each other and things in the "outside world", the group activity promoted better harmony in the ward."

ABSTRACT (Ineff. E.N. reporting on C.N. Acute)

"Patients are hospitalised for long periods and become dependent on drugs as being the only form of therapy. Group therapy could have easily been organised in the ward but was not because the charge nurse did not believe in change."

| <u>Shift</u> (N = 34) | | <u>Specialty</u> (N = 34) | | | <u>Eff. Ineff.</u> (N = 34) | |
|-------------------------|-----|---------------------------|----------|-------|-----------------------------|--------|
| Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| 2 | 32* | 1 | 11 | 22* | 30* | 4 |
| 7 | 27 | 15 | 11 | 8 | 18 | 16 |
| (X ² = 4.5S) | | (X ² = 37.6S) | | | (X ² = 17.0S) | |

| <u>Staff reported on (N = 49)</u> | | | | | |
|-----------------------------------|-------|------|-------------------|------|------|
| C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| 17 | 6 | 12 | 6 | 3 | 5 |
| Patient respondents | | 7 | Other respondents | | 27 |

The night shift opportunities for this activity are clearly limited, this being reflected in the X^2 result. The long stay specialty contained as many incidents as were expected, while the acute specialty had significantly more. The specialty distribution may reflect the perceived value of "groups", particularly in the acute type of specialty. The virtual absence of incidents relating to the therapeutic use of groups in the geriatric specialty tends to be in conflict with what is known about the therapeutic use of groups in geriatric care, for example their considerable usefulness in relation to maximising patients' orientation.

The emphasis on effective incidents may reflect the fact that while the activity is effective its absence is not seen as negative or ineffective.

Summary of distribution of incidents within AREA A "STAFF INITIATED INTERVENTION", Category II "Makes Therapeutic Use Of Environment", Sub-categories 1 - 7.

Shift

For Category II as a whole the vast majority of incidents related to day shift, while the number relating to night shift was significantly greater than expected. Five Sub-categories were submitted to X^2 tests, the results being as follows:

| | |
|--|--------------------|
| No significant differences between shifts; | 1 Sub-category |
| Day shift over-represented | ; 2 Sub-categories |
| Night shift over-represented | ; 2 Sub-categories |

The two Sub-categories in which the night shift were over-represented were:

Sub-category 4 "Individualises patient care. Adapts the environment, routine or care to suit individual patients."

and

Sub-category 6 "Observes or supervises patients."

Both of these may reflect the special nature of patient care during the night shift, namely the supervisory role of the nurse and the need to individualise patient care. The latter feature of care was also reported on in relation to day shift but may be more noticable during night time, due to the wrongly perceived similarity in the needs and behaviour of the majority of patients.

Both the Sub-categories, 2 and 7, which were over-represented in relation to day shift related to activities which are more appropriate to day time activities viz. encouraging independence and making use of staff-patient or patient-patient groups.

Skills in this Category of functioning are clearly not confined to either day or night shift. In short "Makes Therapeutic Use Of Environment" is not shift specific, although some of its Sub-categories are given a greater emphasis within one or other of the two shifts.

Specialty

In Category II the specialty emphasis is on geriatric nursing, although the other two specialties contain 57% of the incidents between them. Thus, while the emphasis may be on the geriatric specialty, both the long stay and acute specialties are well represented at Category level.

The geriatric specialty emphasis did not hold true in all six Sub-categories which were subjected to the χ^2 , the results being as follows;

| | |
|---|------------------|
| No significant difference between specialties ; | 2 Sub-categories |
| Geriatric specialty over-represented ; | 2 Sub-categories |
| Long stay specialty over-represented ; | 1 Sub-category |
| Acute specialty over-represented ; | 2 Sub-categories |

Thus, in making therapeutic use of the environment, nurses in all three specialties were reported as using this skill. While the emphasis in five of the Sub-categories was on one or other of the specialties, all specialties were represented in all the Sub-categories.

Effective-Ineffective Incidents

At Category level, ineffective incidents were significantly over-represented according to the χ^2 test ($\chi^2 = 16.3$). The same was not true at Sub-category level showing the following results on the seven occasions when the χ^2 was applied:

| | |
|--|--------------------|
| No significant Eff-Ineff emphasis | ; 0 Sub-categories |
| Effective incidents over-represented | ; 4 Sub-categories |
| Ineffective incidents over-represented | ; 3 Sub-categories |

The Sub-categories with the over-representation of ineffective incidents related to nursing activity which, if performed badly or not at all, resulted in highly visible undesirable consequences (they related to privacy, patient supervision or observation, and individuality of patient care).

Staff reported on

Although all staff were represented at Category level, the χ^2 detected an emphasis on the enrolled nurse and nursing assistant grades. The enrolled nurse, least qualified of the three trained staff grades, and the nursing assistants, least qualified of the three untrained staff grades were therefore over-represented in relation to the Category as a whole.

The χ^2 was applied to three Sub-categories and was not significant on all three occasions.

AREA A Category III "Effectively Deals With Or Communicates With Relatives." (N = 80)

ABSTRACT (Eff. N.A. reporting on C.N. Ger.)

"A patient had just died in the ward. When her relatives arrived they became very upset and just could not accept the fact that the patient was dead. The charge nurse took the relatives into a side room and allowed them to talk about the patient. After some time they began to accept the death and even asked to see the body, they had previously refused to see the deceased."

ABSTRACT (Ineff. C.N. reporting on Sf.N. Long Stay)

"A relative wanted to take a patient out of hospital permanently because the patient had seemed so "well" during the past few weeks. The discharge was arranged but the staff nurse failed to explain to the relative that the patient might take some time to re-adjust to his new environment. Also, the staff nurse should have tried to persuade the relative to start by having the patient at home for one or two days at a time before arranging a full discharge."

| <u>Shift</u> (N = 80) | | | <u>Specialty</u> (N = 80) | | | <u>Eff. Ineff.</u> (N = 80) | |
|-----------------------|-----------------------------|-----|---------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 12 | 68 | 38* | 15 | 27* | 59* | 21 |
| E. | 14 | 66 | 26 | 28 | 26 | 48 | 32 |
| | (x ² = 0.3 N.S.) | | (x ² = 11.6S) | | | (x ² = 6.3S) | |

| <u>Staff reported on (N = 80)</u> | | | | | | |
|-----------------------------------|--------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 31* | 13* | 14 | 9 | 0 | 13 |
| E. | 20 | 11 | 16 | 10 | 7 | 16 |
| | (x ² = 14.3S) | | | | | |

Patient respondents 6 Other respondents 74

The x² detected an over-representation of incidents in the geriatric and acute specialties, this may be due to the relatively higher number of relatives who visit patients in these specialties. The effective-ineffective emphasis was on the effective incidents,

possibly indicating the skill which nurses have developed in this area of care. The x^2 for "staff reported on" was significant and indicated that two grades of trained staff were over represented in this activity. However, all grades, with the exception of the pupil nurse were involved in this activity.

AREA A Category III Sub-category 1

"Gives relatives correct explanation of, or information relating to patients' illness, treatment or nursing care." (N = 27)

ABSTRACT (Eff. Dr. reporting on E.N. Acute)

"A recently admitted patient was "homesick" and wanted to go home. The nurse interviewed the patient's husband and gave him an explanation of the situation. The explanation and resulting discussion enabled the patient's husband to make an informed decision about taking his wife home."

ABSTRACT (Ineff. C.N. reporting on N.A. Ger.)

"A visitor complained to the nurse that her mother was not wearing her spectacles. The nurse argued with the visitor instead of trying to explain why her mother was not wearing her spectacles. Instead of receiving a satisfactory explanation, the visitor simply became more angry about the spectacles not being worn."

| <u>Shift</u> (N = 27) | | | <u>Specialty</u> (N = 27) | | | <u>Eff. Ineff.</u> (N = 27) | |
|-----------------------|-------|-----|-----------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 3 | 24 | 14 | 5 | 8 | 18 | 9 |
| E. | - | - | 13 | 5 | 9 | 20 | 7 |
| | | | (X ² = 0.2 N.S.) | | | (X ² = 0.8 N.S.) | |

Staff reported on (N = 27)

| C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
|---------------------|-------|------|-------------------|------|------|
| 6 | 6 | 7 | 4 | 0 | 4 |
| Patient respondents | | 0 | Other respondents | | 27 |

Both shifts contained incidents of this type, these being spread as expected through all specialties and between effective/ineffective. All staff with the exception of pupil nurses, were included in the activity.

AREA A Category III Sub-category 2

"Comforts relatives of dying patient." (N = 6)

ABSTRACT (E.N. reporting on N.A. Acute)

"A patient had recently died, the relatives were now in the ward. The nurse made tea for the relatives and gave them general assistance with a great deal of thought and kindness."

ABSTRACT (Ineff. N.O. reporting on C.N. Ger.)

"A patient had died during the morning. When the visitors arrived that afternoon the relatives were simply told that the patient had died. The nurse made no attempt to show an understanding of the relatives feelings or response to the news of the death."

| <u>Shift</u> (N = 6) | | <u>Specialty</u> (N = 6) | | | <u>Ineff. Eff.</u> (N = 6) | |
|----------------------|-----|--------------------------|----------|-------|----------------------------|--------|
| Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| 3 | 3 | 3 | 1 | 2 | 6 | 0 |

Staff reported on (N = 5)

| C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
|------|-------|------|-------|------|------|
| 3 | 0 | 1 | 0 | 0 | 2 |

Patient respondents 0 Other respondents 6

Because of the small numbers of incidents in this sub-category, no further comment will be made.

AREA A Category III Sub-category 3

"Encourages or enables relatives to play an active part in care." (N = 47)

ABSTRACT (Eff. N.A. reporting on E.N. Ger.)

"A dying patient was being visited by her relatives. The nurse arranged for the relatives, at their request, to stay with the patient all night. The patient and her relatives found comfort in the arrangement which the nurse had made."

ABSTRACT (Ineff. Sf.N. reporting on E.N. Ger.)

"An overweight patient was put on a reducing diet. The nurse saw the patient's relatives over-feeding her, contrary to the diet instructions. The nurse failed to inform the relatives of the reducing diet or to involve them in this area of care."

| <u>Shift</u> (N = 47) | | <u>Specialty</u> (N = 47) | | | <u>Eff. Ineff.</u> (N = 47) | |
|-----------------------------|-----|-----------------------------|----------|-------|-----------------------------|--------|
| Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| 6 | 41 | 21 | 9 | 17 | 35 | 12 |
| 7 | 40 | 22 | 9 | 16 | 35 | 12 |
| (X ² = 0.2 N.S.) | | (X ² = 0.1 N.S.) | | | (X ² = 0.0 N.S.) | |

| <u>Staff reported on (N = 47)</u> | | | | | |
|-----------------------------------|-------|------|-------------------|------|------|
| C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| 22 | 7 | 6 | 5 | 0 | 7 |
| Patient respondents | | 6 | Other respondents | | 41 |

The three X² tests in this Sub-category detected no significant difference between shift, specialty, or effective/ineffective incidents, all staff, with the exception of pupil nurse, being included in staff reporting on.

Summary of distribution of incidents within AREA A "STAFF INITIATED INTERVENTION"; Category III "Effectively Deals With Or Communicates With Relatives." Sub-categories 1 - 3

For Category III as a whole the X² detected no significant difference between shift distribution of incidents, but did detect an emphasis on the geriatric and acute specialties. This may reflect

the infrequency with which patients in the Long stay area receive visits from relatives. Effective incidents were significantly greater than expected although 26% of the incidents were ineffective.

A significant difference between grades was detected, with the charge nurse and staff nurse being over-represented, these being the grades who would usually meet and deal with patients relatives. However all grades were reported on with the exception of the pupil nurse. No significant X^2 results were found at Sub-category level.

It could be concluded that this activity is not unique to either shift or any of the three specialties. Also, that all staff grades, with the exception of the pupil nurse, were reported as being involved in this area of care.

AREA A Category IV "Effectively Responds To Patients' Pathological Behaviour" (N = 448)

ABSTRACT (Eff. Dr. reporting on C.N. Acute)

"A female patient was overactive and broke a window. The nurse calmed the patient by talking to her and taking her for a walk."

ABSTRACT (Ineff. St.N. reporting on E.N. Acute)

"The patient was in a hypo-manic state and he kept talking about how to buy or steal new cars, or steal from telephone boxes. The nurse kept asking the patient about these activities, the patient became more stimulated and hypo-manic. Instead of trying to make the patient talk about normal activities, the nurse made the patient invent further stories and jump from subject to subject."

| <u>Shift</u> (N = 448) | | <u>Specialty</u> (N = 448) | | | <u>Eff. Ineff.</u> (N = 448) | |
|------------------------|-----------------------------|----------------------------|-----------------------------|----------|------------------------------|-----------------------------|
| | Night | Day | Ger. | Long St. | Acute | Eff. Ineff. |
| O. | 84 | 364 | 142 | 175 | 131 | 253 195 |
| E. | 79 | 369 | 145 | 157 | 146 | 269 179 |
| | (x ² = 0.4 N.S.) | | (x ² = 3.7 N.S.) | | | (x ² = 2.4 N.S.) |

| <u>Staff reported on</u> (N = 498) | | | | | | |
|------------------------------------|-----------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 115 | 55 | 111 | 73 | 75 | 109 |
| E. | 127 | 68 | 98 | 61 | 41 | 103 |
| | (x ² = 8.9 N.S.) | | | | | |

Patient respondents 24 Other respondents 424

Both shifts were represented in this category, the x² detecting no significant difference in the distribution of incidents between shifts. No significant differences were detected in the distribution of incidents between specialties, effective/ineffective incidents or staff reported on. As will be seen below, this "even" distribution of incidents did not hold good in all Sub-categories of Category III.

AREA A Category IV Sub-category 1

"Responds to aggressive behaviour" (N = 149)

ABSTRACT (Eff. C.N. reporting on Sf.N. Long St.)

"A patient was aggressive and noisy, making a general disturbance in the ward. The nurse spoke quietly to the patient, coaxing her to take a seat. She gave the patient a cigarette, instead of using medication. The patient and the ward generally soon settled down."

ABSTRACT (Ineff. St.N. reporting on C.N. Acute)

"A patient was very abusive and aggressive towards other patients. The charge nurse told him to sit down, behave himself and act his age. This was ineffective because the patient just transferred his anger and abuse from the other patients to the charge nurse. He probably would have become violent towards the nurse if another nurse had not intervened."

| <u>Shift</u> (N = 149) | | | <u>Specialty</u> (N = 149) | | | <u>Eff. Ineff.</u> (N = 149) | |
|------------------------|---------------------------|-----|----------------------------|----------|-------|------------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 27 | 122 | 33 | 60* | 56* | 70 | 79* |
| E. | 28 | 121 | 47 | 58 | 44 | 84 | 65 |
| | (x ² = 0 N.S.) | | (x ² = 7.5 S) | | | (x ² = 5.3 S) | |

| <u>Staff reported on</u> (N = 159) | | | | | | |
|------------------------------------|-----------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 45 | 21 | 37 | 19 | 11 | 26 |
| E. | 37 | 18 | 35 | 24 | 10 | 35 |
| | (x ² = 5.8 N.S.) | | | | | |

Patient respondents 9 Other respondents 140

This Sub-category, the largest in Category IV, contained incidents relating to episodes of actual aggression, verbal and non-verbal. The x² detected no difference in shift distribution but detected significance in relation to Sub-specialty, effective/ineffective and staff reported on distributions.

The long-stay and acute specialties were over-represented, this may reflect a higher level of aggression in these areas. Conversely, it may be indicative of the aggression in the geriatric specialty being more manageable, and subsequently less likely to be commented on. The emphasis was on ineffective incidents although 47% of the incidents were of the effective type. All staff grades were reported on but the x² detecting no significant differences between grades

AREA A Category IV Sub-category 2

"Establishes cause of pathological behaviour" (N = 33)

ABSTRACT (Eff. Dr. reporting on C.N. Acute)

"A charge nurse noted that a patient experienced marked fluctuations in blood pressure, it tended to rise after the patient was visited by his wife. The nurse established a link between the presence of the patient's wife, and an increase in the patient's anxiety level."

ABSTRACT (Ineff. E.N. reporting on Self. Ger.)

"A patient became restless and agitated, he kept getting out of bed. I became impatient with him and kept returning him to bed without trying to establish the cause."

| <u>Shift</u> (N = 33) | | | <u>Specialty</u> (N = 33) | | | <u>Eff. Ineff.</u> (N = 33) | |
|-----------------------|-----------------------------|-----|---------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 7 | 26 | 18* | 9 | 6 | 12 | 21* |
| E. | 6 | 27 | 11 | 13 | 9 | 19 | 14 |
| | (x ² = 0.2 N.S.) | | (x ² = 6.7 S.) | | | (x ² = 6.1 S) | |

| <u>Staff reported on</u> (N = 33) | | | | | | |
|-----------------------------------|---------------------|-------|------|-------------------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 12 | 4 | 9 | 2 | 2 | 4 |
| | Patient respondents | | 2 | Other respondents | | 31 |

Both shifts and all staff grades were included in this activity. The x² relating to effective/ineffective incidents indicated an over-representation of the ineffective type.

AREA A Category IV Sub-category 3

"Focuses patient on reality. Gives patient orientation" (N = 55)

ABSTRACT (Eff. E.N. reporting on C.N. Long St.)

"Ambulant geriatric patients are admitted to this ward. The nurse arranged for the toilet door to be painted a distinctive colour and for a mark to be placed on the floor between the sitting room and the toilet. The patients, although confused, were able to find their way to the toilet."

ABSTRACT (Ineff. E.N. reporting on P.N. Long St.)

"A deaf and dumb patient had delusions about men being under her bed. The nurse failed to move the bed and show the patient there was no-one underneath it, he just took hold of the patient and put her to bed."

| <u>Shift</u> (N = 55) | | | <u>Specialty</u> (N = 55) | | | <u>Eff. Ineff.</u> (N = 55) | |
|-----------------------------|-------|-----|-----------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 8 | 47 | 21 | 15 | 19 | 33 | 22 |
| E. | 10 | 45 | 18 | 22 | 15 | 31 | 24 |
| (X ² = 0.5 N.S.) | | | (X ² = 3.8 N.S.) | | | (X ² = 0.3 N.S.) | |

| <u>Staff reported on</u> (N = 70) | | | | | | |
|-----------------------------------|------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 15 | 7 | 12 | 10 | 9 | 17 |
| E. | 16 | 8 | 16 | 10 | 5 | 15 |
| (X ² = 4.6 N.S.) | | | | | | |

Patient respondents 3 Other respondents 52

None of the four X² tests applied to this Sub-category were significant. Both shifts, all specialties and all six staff grades were included in numbers which did not differ significantly from the expected. This was the only Sub-category in which the X² resulted were identical to that relating to the Category as a whole.

AREA A Category IV Sub-category 4

"Sets limits on patients' behaviour" (N = 10)

ABSTRACT (Eff. St.N. reporting on C.N. Long St.)

"Each time "discharge" was mentioned to this particular patient she would threaten to commit suicide or invent reasons for being unable to go. She was told, in agreement with the doctor, that she would be discharged in a few weeks. This "ultimatum" helped her to a successful discharge."

ABSTRACT (Ineff. N.A. reporting on Sf.N. Long St.)

"A patient deliberately arrived late for his meals every morning. The nurse kept his breakfast warm and allowed him to eat whenever he decided to arrive in the dining room. The nurse should have made it clear to the patient that being late for breakfast would mean no breakfast."

| <u>Shift</u> (N = 10) | | <u>Specialty</u> (N = 10) | | | <u>Eff. Ineff.</u> (N = 10) | |
|-----------------------|-----|---------------------------|----------|-------|-----------------------------|--------|
| Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| 2 | 8 | 3 | 7 | 0 | 10 | 0 |

| <u>Staff reported on</u> (N = 10) | | | | | |
|-----------------------------------|-------|------|-------------------|------|------|
| C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| 2 | 1 | 5 | - | - | 2 |
| Patient respondents | | 0 | Other respondents | | 10 |

χ^2 tests were not applied to incidents in this category because of the small number of incidents.

AREA A Category IV Sub-category 5

"Responds to patients anxiety, over-activity or over-stimulation." (N = 111)

ABSTRACT (Eff. E.N. reporting on Sf.N. Acute)

"A new patient was very anxious about who would look after her dogs while she was in hospital. The charge nurse reassured her and arranged for a nurse to take her to a telephone so that she could arrange for a neighbour to care for her dogs. After making the call, the patient seemed much less anxious and settled quickly into the ward."

ABSTRACT (Ineff. St.N. reporting on P.N. Ger.)

"An elderly patient was terrified at the prospect of having a bath. The pupil nurse just laughed at her and almost threw her into the bath saying "don't be a silly old fool". The nurse should have coaxed the old lady into the bath and made her less afraid."

| <u>Shift</u> (N = 111) | | | <u>Specialty</u> (N = 111) | | | <u>Eff. Ineff.</u> (N = 111) | |
|------------------------|--------------------------|-----|----------------------------|----------|-------|------------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 32* | 79 | 45* | 28 | 38* | 67 | 44 |
| E. | 21 | 90 | 35 | 43 | 33 | 63 | 48 |
| | (x ² = 7.1 S) | | (x ² = 8.8 S) | | | (x ² = 0.6 N.S.) | |

| Staff reported on (N = 121) | | | | | | |
|-----------------------------|------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 22 | 14 | 31 | 17 | 5 | 32 |
| E. | 28 | 13 | 27 | 18 | 9 | 26 |

($\chi^2 = 5.2$ N.S.)

Patient respondents 9 Other respondents 102

The χ^2 detected over-representation of incidents relating to night shift, the acute and geriatric specialties.

The night shift emphasis may reflect the time context in which the behaviour takes place, it may be that the same patient behaviour occurring in day time is less problematic and attracts less attention. All staff grades were reported on, there being no significant differences between grades.

AREA A Category IV Sub-category 6

"Negatively reinforces pathological behaviour" (N = 82)

ABSTRACT (Eff. C.N. reporting on self. Long St.)

"A patient was too lazy to shave and bath properly. He would spill food all over the table, walk around with his laces untied and his hair uncombed. The nurse offered rewards of cigarettes, increased parole and participation in ward outings if the patient would improve his personal hygiene and improve his personal appearance and social functioning."

ABSTRACT (Ineff. E.N. reporting on N.A. Ger.)

"A patient would go into a temper tantrum and lie on the floor refusing to get up. The nurse used a wheel-chair to take the patient to the toilet, to her bed and for meals. This encouraged the patient to keep having tantrums."

| <u>Shift</u> (N = 82) | | | <u>Specialty</u> (N = 82) | | | <u>Eff. Ineff.</u> (N = 82) | |
|-----------------------|-------------------------|-----|---------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 4 | 78* | 19 | 53* | 10 | 53 | 29 |
| E. | 15 | 67 | 26 | 32 | 24 | 46 | 36 |
| | (X ² = 9.9S) | | (X ² = 23.8S) | | | (X ² = 2.4 N.S.) | |

| Staff reported on (N = 97) | | | | | | |
|----------------------------|-----------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 26 | 8 | 20 | 18 | 6 | 19 |
| E. | 22 | 11 | 22 | 14 | 7 | 21 |
| | (X ² = 3.2 N.S.) | | | | | |

Patient respondents 1 Other respondents 81

Day shift incidents, and those relating to the long stay sub-specialty were the only over-represented areas detected by the X². Many of the incidents related to patient behaviour in the social skills area, for example self care, arriving for meals on time and conforming to ward rules and regulations. This may account for the day shift emphasis since few of these activities were available to patients during the night time.

The long-stay sub-specialty over-representation may reflect the existence of more opportunity for nurse to apply a behavioural approach to patient care, or an increased level of opportunities for using this approach.

All staff grades were reported on, the X² detecting no significant difference between staff grades.

AREA A Category IV Sub-category 7

"Anticipates and minimises, or prevents, pathological behaviour." (N = 8)

ABSTRACT (Eff. E.N. reporting on C.N. Long St.)

"One evening the charge nurse noticed that the patients seemed to be particularly restless. He decided to hold a social event in the ward and prevented a situation where violence could have occurred in the ward."

| <u>Shift</u> (N = 8) | | | <u>Specialty</u> (N = 8) | | | <u>Eff. Ineff.</u> (N = 8) | |
|----------------------|-------|-----|--------------------------|----------|-------|----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 4 | 4 | 3 | 3 | 2 | 8 | 0 |

| <u>Staff reported on</u> (N = 8) | | | | | | |
|----------------------------------|------|-------|------|-------------------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 1 | 2 | 4 | 0 | 0 | 1 |
| Patient respondents | | | 0 | Other respondents | | |
| | | | | 8 | | |

Small numbers of incidents prevented the application of the χ^2 in this Sub-category. Perhaps the significance of the numbers of incidents in this Sub-category is that there are so few of them (8), indicating the relative infrequency with which nurses anticipate and prevent pathological behaviour.

Summary of distribution of incidents in AREA A "STAFF INITIATED INTERVENTION", Category IV "Effectively Responds To Patients' Pathological Behaviour" Sub-categories 1 - 7.

Shift

For Category IV as a whole, the majority of incidents related to day shift but the χ^2 detected no significant difference in the shift distribution. Five Sub-categories were submitted to the χ^2 test, the results being as follows:

| | |
|--|--------------------|
| No significant difference between shifts | ; 3 Sub-categories |
| Day shift over-represented | ; 1 Sub-category |
| Night shift over-represented | ; 1 Sub-category |

Skills in this category of functioning are clearly not confined to either day or night shift. Exception to this at Sub-category level are "Responds to patients' anxiety, over-activity or over stimulation" (NIGHT SHIFT emphasis) and "Negatively reinforces pathological behaviour (DAY SHIFT emphasis).

Specialty

At Category level there was no significant difference in the distribution of incidents between specialties, although this did not hold true for the Sub-categories. Five Sub-categories were submitted to the X^2 test, the results being as follows:

| | |
|---|--------------------|
| No significant difference between specialties | ; 1 Sub-category |
| Geriatric specialty over-represented | ; 2 Sub-categories |
| Long stay specialty over-represented | ; 2 Sub-categories |
| Acute specialty over-represented | ; 2 Sub-categories |

Thus, in relation of "Effectively responds to patients' pathological behaviour", nurses in all three specialties were reported as using this skill.

Effective-Ineffective Incidents

At Category level, neither effective or ineffective incidents were over-represented, although the same did not hold true at Sub-category level. The X^2 was applied to five Sub-categories with the following results:

| | |
|--|--------------------|
| No significant Eff-Ineff emphasis | ; 3 Sub-categories |
| Effective incidents over-represented | ; 0 Sub-categories |
| Ineffective incidents over-represented | ; 2 Sub-categories |

The Sub-category in which the ineffective incidents were over-represented "Responds to aggressive behaviour" represents an area of activity where many nurses have relatively little experience because experience at dealing with aggressive behaviour can only be obtained on the very few occasions on which it occurs. This may explain the ineffective emphasis, alternatively the emphasis on ineffective incidents may point to more training on this area being required.

Staff reported on

All staff grades were represented at Category level, in numbers not differing significantly from the expected. The X^2 was applied to four Sub-categories with the following results:

| | |
|--|--------------------|
| No significant difference between grades | ; 4 Sub-categories |
|--|--------------------|

It should also be noted that the number of incidents relating explicitly to preventing or understanding pathological behaviour (Sub-categories 2 and 7) totalled 41 or 9% of this incidents in this Category. The number of incidents relating to dealing with the pathological behaviour (Sub-categories 1, 3, 4, 5 and 6) totalled 407, or 91% of the incidents in this Category.

AREA A Category V "Functions As Part Of A Therapeutic Team"
(N = 325)

ABSTRACT (Eff. Dr. reporting on C.N. Acute)

"A haphazard method of calculating patients' reward for work existed, different criteria being applied by different staff groups. The charge nurse arranged for the staff groups concerned to meet and decide on a common policy. This resulted in a marked sense of participation and awareness of the total method of patient assessment."

ABSTRACT (Ineff. E.N. reporting on C.N. Ger.)

"When I came on duty I was not given a full report by the charge nurse. I was not made familiar with the ward routine or of the individual needs of each patient."

| <u>Shift</u> (N = 325) | | | <u>Specialty</u> (N = 325) | | | <u>Eff. Ineff.</u> (N = 325) | |
|------------------------|-----------------------------|-----|-----------------------------|----------|-------|------------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 63 | 262 | 108 | 114 | 103 | 173 | 152* |
| E. | 58 | 267 | 105 | 114 | 106 | 195 | 130 |
| | (X ² = 0.5 N.S.) | | (X ² = 0.2 N.S.) | | | (X ² = 6.2S) | |

| <u>Staff reported on (N = 390)</u> | | | | | | |
|------------------------------------|------|-------------------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 143* | 57* | 80* | 37 | 28 | 45 |
| E. | 100 | 53 | 77 | 47 | 32 | 81 |
| $(X^2 = 37.5S)$ | | | | | | |
| Patient respondents | 42 | Other respondents | | 283 | | |

Both shifts were represented in this Sub-category, the X^2 detecting no significant difference between shifts, the same being true of the three Specialties. Ineffective incidents were over-represented at Category level, although this held true for only one of the two Sub-categories. The X^2 detected a significant difference in the distribution of incidents between grades. Although all grades were reported on, trained staff grades were reported on significantly more often than the untrained staff.

The emphasis on ineffective incidents, in combination with over-representation of trained staff, may reflect the inability of these staff groups to adequately maximise staff contribution in terms of team efforts.

AREA A Category V Sub-category 1

"Complies with treatment programme or approach agreed by the team." (N = 100)

ABSTRACT (Eff. C.N. reporting on Self. Long St.)

"The working patients were not being treated equally. I arranged a meeting with the nursing, industrial-therapy, domestic staff and patients. We decided on criteria on which the patients would be assessed and paid."

ABSTRACT (Ineff. Patient reporting on E.N. Acute)

"I started to worry, thinking I would never get better. The nurse said that what I was needing was a couple of E.C.T. (electro-convulsive-therapy) treatments to shock me out of my worrying and depression. This advice contradicted what the doctor had told me, he said I could be treated without drugs or E.C.T."

| <u>Shift</u> (N = 100) | | | <u>Specialty</u> (N = 100) | | | <u>Eff. Ineff.</u> (N = 100) | |
|------------------------|---------------------------|-----|-----------------------------|----------|-------|------------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 18 | 82 | 29 | 31 | 40 | 22 | 78* |
| E. | 19 | 81 | 33 | 35 | 32 | 53 | 47 |
| | (X ² = 0 N.S.) | | (X ² = 2.9 N.S.) | | | (X ² = 38.6S) | |

| <u>Staff reported on</u> (N = 120) | | | | | | |
|------------------------------------|-----------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 41 | 16 | 26 | 14 | 8 | 15 |
| E. | 44 | 17 | 25 | 11 | 9 | 14 |
| | (X ² = 1.3 N.S.) | | | | | |

Patient respondents 5 Other respondents 95

The X² detected no significant differences in the distribution of incidents between shift, specialties or staff reported on. The X² detected an emphasis on ineffective incidents (78%), many of which highlighted the great importance of the health care staff working as a team.

AREA A Category V Sub-category 2

"Keeps self and others aware of clinical data relating to patient. Obtains or encourages, when necessary, non-nursing care for patient, for example, from doctor or chiroprapist."

(N = 225)

ABSTRACT (Eff. N.A. reporting on charge nurse. Ger.)

"It is important to know about the patients you are caring for. The charge nurse arranged for all the nursing assistants to attend the meetings to discuss patient care. Previously, only trained staff had been allowed to attend. This was effective because it helped me to get to know about the patients, their background and the nursing and medical needs."

ABSTRACT (Ineff. E.N. reporting on C.N. Ger.)

"I was on night duty and a particular patient had not slept for five nights, I reported this to the day shift charge nurse several times. The charge nurse failed to pass the information and request for night sedation, on to the doctor. The patient had a total of ten nights without a good sleep until the staff eventually got the doctor to prescribe the night sedation."

| <u>Shift</u> (N = 225) | | | <u>Specialty</u> (N = 225) | | | <u>Eff. Ineff.</u> (N = 225) | |
|------------------------|-----------------------------|-----|-----------------------------|----------|-------|------------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 45 | 180 | 79 | 83 | 63 | 151* | 74 |
| E. | 43 | 182 | 74 | 79 | 72 | 119 | 106 |
| | (X ² = 0.1 N.S.) | | (X ² = 1.6 N.S.) | | | (X ² = 18.3S) | |

| <u>Staff reported on (N = 270)</u> | | | | | | |
|------------------------------------|-----------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 102 | 41 | 54 | 23 | 20 | 30 |
| E. | 99 | 39 | 56 | 26 | 19 | 31 |
| | (X ² = 0.7 N.S.) | | | | | |

Patient respondents 37 Other respondents 188

The only significant X² result related to an over-representation of effective incidents. The incidents generally referred to data collection or dissemination, or securing non-nursing (mainly medical) care for the patients.

Both shifts, all three specialties and all six staff grades were included in the incidents, the X² detecting no significant differences.

Summary of distribution of incidents in AREA A "STAFF INITIATED THERAPEUTIC INTERVENTIONS" Category V "Functions As Part Of A Therapeutic Team", Sub-categories 1 - 2

The activity "functions as part of a therapeutic team" was not found to be shift or specialty specific, this held true at Category and Sub-category levels.

Ineffective incidents were over-represented at Category level, and in one of the Sub-categories (Sub-category 1). This may be indicative of nurses being less able to function as part of a team (Sub-category 1) than to function as information collectors and disseminators. This finding, relating as it does to a staff group who are heavily committed to team work, is rather remarkable, and suggests further study of the role and organisation of team-work as it relates to patient care generally and nursing care in particular.

Trained staff were over-represented at Category level, but this did not hold true at Sub-category level.

It may be concluded that the skill required to function as part of a therapeutic team is neither shift, specialty nor grade specific in relation to the Sub-categories within AREA A, Category V.

AREA B "ADMINISTRATIVE ACTIVITY" (N = 91)

ABSTRACT (Eff. C.N. reporting on Self. Acute)

"A patient ran out of money for cigarettes. I filled out a form authorising him to draw money from his account."

ABSTRACT (Ineff. N.O. reporting on C.N. Acute)

"The nurse gave out the medications on his own and without checking the identity of each patient, this resulted in one patient being given the wrong medicine. The nurse should have complied with the procedure which states that two nurses should give out the medications and that the identity of each patient should be checked."

| <u>Shift</u> (N = 91) | | <u>Specialty</u> (N = 91) | | | <u>Eff. Ineff.</u> (N = 91) | |
|-----------------------|-----------------------------|---------------------------|-----------------------------|----------|-----------------------------|-------------------------|
| | Night | Day | Ger. | Long St. | Acute | Eff. Ineff. |
| O. | 19 | 72 | 26 | 39 | 26 | 41 50* |
| E. | 19 | 72 | 34 | 30 | 27 | 53 38 |
| | (X ² = 0.0 N.S.) | | (X ² = 4.6 N.S.) | | | (X ² = 6.5S) |

| <u>Staff reported on (N = 91)</u> | | | | | | |
|-----------------------------------|-------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 37* | 16* | 18 | 4 | 3 | 13 |
| E. | 23 | 12 | 18 | 11 | 7 | 20 |
| | (X ² = 19 S) | | | | | |

Patient respondents 19 Other respondents 72

At AREA level, "ADMINISTRATIVE ACTIVITY" is neither shift or specialty specific. The majority of incidents were ineffective (55%), the X² detecting an over-representation in the number of ineffective incidents.

Although all staff grades were reported on, the two grades of registered nurse (charge nurse and staff nurse) were over-represented. The emphasis on these two staff grades is not surprising in view of their formal leadership and administrative role within the ward. However, the emphasis, accompanied as it is with the emphasis on ineffective incidents, may point to an area

of weakness in an important aspect of the role of the staff nurse and charge nurse grades.

AREA B Category I "Ensures Availability Of Non-Clinical Patient Data." (N = 18)

ABSTRACT (Eff. C.N. reporting on Self. Acute)

"When I came on duty I checked the ward to make sure all the patients were present. This is essential to make sure that none of the patients have wandered away from the ward."

ABSTRACT (Ineff. Sf.N. reporting on E.N. Acute)

"The nurse was completing the form recording patient movements into and out of the ward, admission and discharges for example. He recorded a patient as being "discharged" when the patient was actually on pass. The nurse should always know all details of the movements of all patients."

| <u>Shift</u> (N = 18) | | | <u>Specialty</u> (N = 18) | | | <u>Eff. Ineff.</u> (N = 18) | |
|-----------------------|---|-----|---------------------------|----------|-------|-----------------------------|--------|
| Night | | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 8 | 10 | 3 | 6 | 9 | 7 | 11 |

| <u>Staff reported on</u> (N = 18) | | | | | | |
|-----------------------------------|------|-------|------|-------------------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 8 | 1 | 4 | 2 | - | 3 |
| Patient respondents | | | 4 | Other respondents | | |
| | | | | 14 | | |

The small numbers of incidents prevented the application of the X^2 test. The majority of incidents were ineffective and reflected the overt and serious consequences of failure to ensure availability of non-clinical patient data.

AREA B Category I Sub-category 1

"Is aware of the identity of patients" (N = 13)

ABSTRACT (Ineff. St.N. reporting on Sf.N. Acute)

"An old man wandered away from the ward and was lost for several hours. The nurse had failed to record a physical description of the patient (height, weight, etc.) The staff on duty were unable to give the police a physical description of the patient."

| <u>Shift</u> (N = 13) | | | <u>Specialty</u> (N = 13) | | | <u>Eff. Ineff.</u> (N = 13) | |
|-----------------------|-----|---|---------------------------|----------|-------|-----------------------------|--------|
| Night | Day | | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 4 | 9 | 2 | 3 | 8 | 4 | 9 |

| <u>Staff reported on</u> (N = 13) | | | | | | |
|-----------------------------------|------|-------|------|-------------------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 6 | 1 | 3 | 2 | 0 | 1 |
| Patient respondents | | | 2 | Other respondents | | |
| | | | | 11 | | |

The majority of incidents were ineffective and related to serious consequences arising from an inability to identify, or produce a description, of individual patients.

The small number of incidents in this Sub-category prevented the application of χ^2 .

AREA B Category I Sub-category 2

"Is familiar, when necessary, with the location of patients in her care." (N = 5)

ABSTRACT (Ineff. C.N. reporting on N.A. Ger.)

"The nurse failed to acquaint herself with the identity of her patients. She undressed a particular patient and put her in the wrong bed."

| <u>Shift</u> (N = 5) | | | <u>Specialty</u> (N = 5) | | | <u>Eff. Ineff.</u> (N = 5) | |
|----------------------|-----|---|--------------------------|----------|-------|----------------------------|--------|
| Night | Day | | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 4 | 1 | 1 | 3 | 1 | 3 | 2 |

| <u>Staff reported on (N = 5)</u> | | | | | | |
|----------------------------------|---------------------|-------|------|-------------------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 2 | 0 | 1 | 0 | 0 | 2 |
| | Patient respondents | | 2 | Other respondents | | 3 |

The small numbers of incidents in this Sub-category prevented the application of χ^2 .

AREA B Category II "Ensures That Adequate Stocks Of Equipment And Supplies Are Available." (N = 42)

ABSTRACT (Eff. E.N. reporting on Self. Ger.)

"A patient was developing a pressure sore and required to be placed on a ripple bed. I arranged with the central store to have a ripple bed sent to the ward right away."

ABSTRACT (Ineff. C.N. reporting on Sf.N. Ger.)

"The nurse was ordering the pharmacy stores, pill etc. She ordered the fresh supplies without making sure that a sufficient amount were ordered. This was ineffective because it resulted in another nurse having to be sent to the pharmacy to collect further stores."

| <u>Shift</u> (N = 42) | | | <u>Specialty</u> (N = 42) | | | <u>Eff. Ineff.</u> (N = 42) | |
|-----------------------|-------------------------------|-----|-------------------------------|----------|-------|-------------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 9 | 33 | 19 | 13 | 10 | 20 | 22 |
| E. | 8 | 34 | 14 | 15 | 13 | 22 | 20 |
| | $(\chi^2 = 0.1 \text{ N.S.})$ | | $(\chi^2 = 3.1 \text{ N.S.})$ | | | $(\chi^2 = 0.4 \text{ N.S.})$ | |

Staff reported on (N = 42)

| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
|----|------|-------|------|-------|------|------|
| O. | 17 | 10 | 7 | 1 | 1 | 6 |

Patient respondents 9 Other respondents 33

AREA B Category III "Protects And Secures Patients' Property"
(N = 31)

ABSTRACT (Eff. P.T. reporting on C.N. Long St.)

"The charge nurse looks after my money for me. He gets it for me any time I need some cash. It is good to have someone to look after your money for you."

ABSTRACT (Ineff. St.N. reporting on Sf.N. Long St.)

"A patient was away on holiday for one week. She tended to hoard things which she kept in a suitcase. While the patient was on holiday the nurse "cleaned out" the patient's possessions and took some away. This was ineffective because the patient became very upset when she got back from holiday and discovered that some of her things had been taken away."

| <u>Shift</u> (N = 31) | | | <u>Specialty</u> (N = 31) | | | <u>Eff. Ineff.</u> (N = 31) | |
|-----------------------------|-------|-----|---------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 2 | 29 | 4 | 20* | 7 | 14 | 17 |
| E. | 6 | 25 | 9 | 13 | 9 | 14 | 17 |
| (X ² = 3.3 N.S.) | | | (X ² = 6.9 S) | | | (X ² = 0 N.S.) | |

| <u>Staff reported on (N = 31)</u> | | | | | |
|-----------------------------------|-------|------|-------------------|------|------|
| C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| 12 | 5 | 7 | 1 | 2 | 4 |
| Patient respondents | | 6 | Other respondents | | 25 |

The χ^2 detected an emphasis on incidents relating to the Long Stay specialty. All staff grades were reported on.

AREA B Category III Sub-category 1

"Arranges for, or offers security for, patients' property. Maintains current list of property and informs patients, when necessary, of location of property." (N = 20)

ABSTRACT (Eff. Pt. reporting on C.N. Long St.)

"The nurse took my money into safe-keeping and helped me to budget my spending. This helped me to control my money and prevented me from spending too much."

ABSTRACT (Ineff. St.N. reporting on Sf.N. Acute)

"A confused gentleman was worried about the loss of money from his locker. The staff nurse, who had removed the money for safe-keeping in the ward safe, simply said "I will attend to it". The patient continued to be worried about where his money had gone."

| <u>Shift (N = 20)</u> | | | <u>Specialty (N = 20)</u> | | | <u>Eff. Ineff. (N = 20)</u> | |
|-----------------------------|-------|-----|-------------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 2 | 18 | 2 | 13 | 5 | 11 | 9 |
| E. | 2 | 18 | - | - | - | 10 | 10 |
| $(\chi^2 = 0 \text{ N.S.})$ | | | $(\chi^2 = 0.2 \text{ N.S.})$ | | | | |

| <u>Staff reported on (N = 20)</u> | | | | | |
|-----------------------------------|-------|------|-------------------|------|------|
| C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| 10 | 3 | 4 | 1 | 1 | 1 |
| Patient respondents | | 4 | Other respondents | | 16 |

Both shifts, all specialties and all staff grades were included in this activity.

AREA B Category III Sub-category 2

"Shows respect and concern for patients' property." (N = 6)

ABSTRACT (Ineff. E.N. reporting on C.N. Long St.)

"The patient's locker was due to be tidied up, the staff nurse cleaning out the locker found letters which were more than ten years old. Because the patient was a "hoarder", the staff nurse put the letters in the dust bin. When the patient discovered what had happened to the letters she became very agitated and abusive, although she was normally not so. The patient had to be sedated with drugs."

| <u>Shift</u> (N = 6) | | | <u>Specialty</u> (N = 6) | | | <u>Eff. Ineff.</u> (N = 6) | |
|----------------------|---|-----|--------------------------|----------|-------|----------------------------|--------|
| Night | | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 0 | 6 | 2 | 3 | 1 | 1 | 5 |

| <u>Staff reported on</u> (N = 6) | | | | | | |
|----------------------------------|------|-------|------|-------------------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 1 | 2 | 1 | 0 | 0 | 2 |
| Patient respondents | | | 2 | Other respondents | | 4 |

The small number of incidents in this Sub-category prevented the χ^2 being applied.

Five, out of the six, incidents were ineffective and all related to staff removing patients' property without consulting with, or obtaining the permission of the patient.

AREA B Category III Sub-category 3

"Arranges for laundering or repair of clothing." (N = 5)

ABSTRACT (Eff. N.A. reporting on Self. Long St.)

"When tidying out the patients' lockers I put out their dirty clothes for laundering. This helps the patients to keep clean and tidy."

| <u>Shift</u> (N = 5) | | | <u>Specialty</u> (N = 5) | | | <u>Eff. Ineff.</u> (N = 5) | |
|----------------------|-------|-----|--------------------------|----------|-------|----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 0 | 5 | 0 | 4 | 1 | 2 | 3 |

| <u>Staff reported on</u> (N = 5) | | | | | | |
|----------------------------------|------|-------|------|-------------------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 1 | 0 | 2 | 0 | 1 | 1 |
| Patient respondents | | | 0 | Other respondents | | |
| | | | | 5 | | |

The small number of incidents in this Sub-category prevent further comment being made.

Summary of distribution of incidents in AREA B "ADMINISTRATIVE ACTIVITY"

The ninety one incidents in this AREA accounted for 2% of the total incidents. At AREA level there was no shift or specialty emphasis and, while the staff reported on emphasis was on the charge nurse and staff nurse grades, all grades were reported on.

The limited amount of data prevented full application of the χ^2 test at Sub-category level, however, when it was applied the following results were obtained:

| <u>Shift</u> | <u>No. of χ^2 Tests</u> |
|---|---|
| Area level: No significant difference | 1 |
| Category level: No significant difference | 2 |
| Sub-category | 0 |

| <u>Specialty</u> | |
|--|---|
| Area level: No significant difference | 1 |
| Category level: Significant difference (Ger. emphasis) | 1 |
| No significant difference | 1 |
| Sub-category level: No χ^2 tests performed | |

| <u>Effective/Ineffective</u> | |
|--|---|
| Area level: Ineffective incidents over-represented | 1 |
| Category level: No significant difference | 2 |
| Sub-category level: No significant difference | 1 |

Staff reported on

No. of X^2 Tests

Area level: Charge nurse and staff nurse
over-represented, no other X^2 tests
performed.

1

AREA C "PROVIDES, PLANS FOR OR MONITORS PHYSICAL CARE" (N = 874)

ABSTRACT Eff. St.N. reporting on Sf.N. Acute)

"A patient developed an epileptic seizure. The nurse took the patient away from potentially dangerous objects and cleared other patients out of the way. This prevented the patient from hurting himself and it avoided other patients becoming disturbed."

ABSTRACT (Ineff. Pt. reporting on C.N. Long St.)

"When I was admitted I asked the doctor to prescribe sleeping tablets for me, which he did. The nurse refused to give me the night sedation which had been prescribed. As a result, I spent a restless night. I got no explanation and I lost faith in the profession."

| <u>Shift</u> (N = 874) | | | <u>Specialty</u> (N = 874) | | | <u>Eff. Ineff.</u> (N = 874) | |
|------------------------|--------------------------|-----|----------------------------|----------|-------|------------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 282* | 592 | 477* | 234 | 163 | 545* | 329 |
| E. | 182 | 692 | 325 | 292 | 257 | 509 | 365 |
| | (x ² = 69.4S) | | (x ² = 116.9S) | | | (x ² = 6.1S) | |

| <u>Staff reported on</u> (N = 989) | | | | | | |
|------------------------------------|--------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 182 | 139* | 210* | 98 | 68* | 292* |
| E. | 254 | 133 | 195 | 114 | 76 | 217 |
| | (x ² = 50.1S) | | | | | |

Patient respondents 135 Other respondents 739

Area C, containing 19.5% of all incidents, was the second largest of the four areas in the classification system. All four x² tests which were applied to the data at AREA level were significant showing an over-representation of incidents in relation to: night shift, geriatric specialty, effective incidents and the pupil, nursing assistant, enrolled and staff nurse grades.

This emphasis did not hold good throughout all Categories and Sub-categories in AREA C.

The night shift emphasis may simply reflect the delivery of physical care predominating during night time, the same being true of the Geriatric emphasis, this group being known to require more

physical care than the other two. The Staff reported on χ^2 suggests that the less, rather than more, qualified staff played a major part in this area of care.

AREA C Category I "Administers Medications" (N = 113)

ABSTRACT (Eff. C.N. reporting on St.N. Acute)

"The student nurse noticed that the patient saving his pills instead of taking them, she had seen him taking his medication out of his mouth and placing it in his pocket. She began crushing his pills and making sure that he swallowed them. The patient's condition began to improve and the nurse probably stopped the patient from taking an overdose."

ABSTRACT (Ineff. St.N. reporting on C.N. Acute)

"A hypo-manic patient was prescribed LARGACTIL (100 mgm Q.I.D.) and SERENACE (1 mgm Q.I.D.). This made his mood and behaviour quite stable. The night nurse did not administer the 10 p.m. dose on three occasions because the patient forgot to come for it. Because of this, he became more disturbed and had to be prescribed further medication and extra night sedation."

| <u>Shift</u> (N = 113) | | | <u>Specialty</u> (N = 113) | | | <u>Eff. Ineff.</u> (N = 113) | |
|------------------------|-------------------|-----|----------------------------|----------|-------|------------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 23 | 90* | 22 | 58* | 33* | 74 | 39 |
| E. | 36 | 77 | 62 | 30 | 21 | 71 | 42 |
| | $(\chi^2 = 6.9S)$ | | $(\chi^2 = 58.8S)$ | | | $(\chi^2 = 0.3 NS)$ | |

| <u>Staff reported on</u> (N = 118) | | | | | | |
|------------------------------------|--------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 43* | 31* | 26* | 12 | 2 | 4 |
| E. | 21 | 17 | 25 | 12 | 8 | 35 |
| | $(\chi^2 = 66.6S)$ | | | | | |

Patient respondents 53 Other respondents 60

The day shift emphasis is to be expected in view of the greater volume of "medication type" activities during the day time. The specialty emphasis is contrary to that of the area as a whole, but

may reflect an increased amount of medications being used in the acute specialty. Predictably, the staff reported on emphasis was on the three trained staff grades, these being the grades most likely to be involved in distributing medication. However it is interesting to note that the three untrained staff grades, including nursing assistants, were also involved in this activity.

AREA C Category I Sub-category 1

"Administers medications carefully, accurately and as prescribed." (N = 86)

ABSTRACT (Eff. P.N. reporting on C.N. Long Stay)

"The patient had been prescribed medication. The charge nurse made positively sure of the amount of medication, time of administration and identity of patient before giving the drug. This makes sure that medications are given accurately and according to the prescription."

ABSTRACT (Ineff. E.N. reporting on E.N. Acute)

"A patient was being transported to another hospital by ambulance. He was upset by the trip and by the transfer. The nurse gave him medication which had not been prescribed by the doctor."

| | <u>Shift</u> (N = 86) | | <u>Specialty</u> (N = 86) | | | <u>Eff. Ineff.</u> (N = 86) | |
|----|-----------------------------|-----|-----------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 15 | 71 | 11 | 53 | 22 | 55 | 31 |
| E. | 18 | 68 | 17 | 44 | 25 | 57 | 29 |
| | (X ² = 0.6 N.S.) | | (X ² = 4.3 N.S.) | | | (X ² = 0.2 N.S.) | |

Staff reported on (N = 91)

| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
|----|-----------------------|-------|----------------------|-------|------|------|
| O. | 39 | 24 | 16 | 8 | 1 | 3 |
| | Patient respondents 1 | | Other respondents 85 | | | |

The χ^2 detected no significant difference in the distribution of incidents relating to shift, specialty or effective-ineffective. While the χ^2 will not be applied to staff reported on, it was clear that the trained staff grades (C.N., Sf.N. and E.N.) predominated.

AREA C Category I Sub-category 2

"Ensures, by observation or assistance, that medications are taken" (N = 22)

ABSTRACT (Eff. E.N. reporting on Sf.N. Acute)

"An old lady refused to take her medication because she had difficulty swallowing pills. The nurse crushed the pills and explained that they would be much easier to swallow with a drink of water. The patient managed to take her pills."

ABSTRACT (Ineff. Sf.N. reporting on E.N. Acute)

"The nurse opened up the medicine trolley and began giving out the medicines to the patients who were lined up in the duty room. The nurse allowed the patients to wander away before they had swallowed their pills. This was ineffective because she failed to make sure that each patient swallowed their pills. Some patients could throw away their pills or save them for a suicide bid."

| | <u>Shift</u> (N = 22) | | <u>Specialty</u> (N = 22) | | | <u>Eff. Ineff.</u> (N = 22) | |
|----|-----------------------|-----|---------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 7 | 15 | 11 | 3 | 8 | 16 | 6 |
| E. | - | - | - | - | - | 15 | 7 |

($\chi^2 = 0.2$ N.S.)

| <u>Staff reported on</u> (N = 22) | | | | | | |
|-----------------------------------|------|-------|------|-------------------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 3 | 5 | 9 | 3 | 1 | 1 |
| Patient respondents | | | 3 | Other respondents | | |
| | | | | 19 | | |

The χ^2 was not applied to incidents in this Sub-category.

AREA C Category I Sub-category 3

"Observes and monitors side effects of medications" (N = 5)

ABSTRACT (Eff. Sf.N. reporting on Sf.N. Acute)

"A recently admitted patient was receiving both sedative and pain killing drugs. He developed respiratory failure as a result of the medication, the nurse noticed this and immediately notified the doctor. This enabled the patient to be seen quickly and given the appropriate antidote. It also demonstrated his knowledge of drug side effects and the physical dangers."

| <u>Shift</u> (N = 5) | | | <u>Specialty</u> (N = 5) | | | <u>Eff. Ineff.</u> (N = 5) | |
|----------------------|---|-----|--------------------------|----------|-------|----------------------------|--------|
| Night | | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 1 | 4 | 0 | 2 | 3 | 3 | 2 |

Staff reported on (N = 5)

| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
|---------------------|------|-------|------|-------------------|------|------|
| O. | 1 | 2 | 1 | 1 | - | - |
| Patient respondents | | | 0 | Other respondents | | |
| | | | | 5 | | |

The χ^2 was not applied to incidents in this Sub-category.

Summary of incidents in AREA C "PROVIDES, PLANS FOR OR MONITORS PHYSICAL CARE", Category I "Administers Medications", Sub-categories 1 - 3.

Shift

For Category I as a whole the day shift was over-represented this did not hold true for the Sub-categories where one applied χ^2 test showed no significant difference.

Specialty

Whilst the Long stay and acute specialties were over-represented at Category level, the single χ^2 applied at Sub-category level found no significant difference in the distribution of incidents between specialties.

Staff reported on

The only X^2 applied to this distribution was at Category level with the three trained staff grades (C.N., Sf.N. and E.N.) being over-represented, suggesting that administering medication is a more evident feature of the trained nurse role, as opposed to the role of the untrained nurse.

It can be concluded that incidents relating to "ADMINISTERS MEDICATIONS" is neither shift or specialty specific. Also, while the trained staff grades predominate in relation to this activity, all staff grades have a role to play in relation to it.

AREA C Category II "Gives Physical Care" (N = 761)

ABSTRACT (Eff. C.N. reporting on St.N. Ger.)

"A patient was having difficulty undressing due to the position of the zip fastener at the back of her dress. She asked a nurse to come to her and help. The nurse knew that the patient would have difficulty with all of her clothes so she undressed her completely. This was effective because it saved the patient from making frequent requests for assistance."

ABSTRACT (Ineff. N.O. reporting on C.N. Acute)

"A group of patients normally have a walk each morning unaccompanied by nursing staff. An elderly patient who was confined to a wheelchair wished to go with the walking party one morning. Because of the shortage of staff, the charge nurse allowed wheelchair patient to be taken out by the other patients. The elderly patient may have come to some harm leaving the hospital open to some form of litigation."

| <u>Shift</u> (N = 761) | | | <u>Specialty</u> (N = 761) | | | <u>Eff. Ineff.</u> (N = 761) | |
|------------------------|---------------------------|-----|----------------------------|----------|-------|------------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 259 | 502 | 455* | 176 | 130 | 471 | 290 |
| E. | 246 | 515 | 416 | 203 | 142 | 475 | 286 |
| | (X ² = 1 N.S.) | | (X ² = 8.3S) | | | (X ² = 0 N.S.) | |

| <u>Staff reported on</u> (N = 871) | | | | | | |
|------------------------------------|-----------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 139 | 108 | 184 | 86 | 66 | 288 |
| E. | 159 | 123 | 185 | 86 | 61 | 257 |
| | (X ² = 8.5 N.S.) | | | | | |

Patient respondents 82 Other respondents 679

Incidents relating to "Gives Physical Care" were distributed as expected between shifts and ineffective-effective. All staff grades were reported on, the X² detecting no significant difference between grades.

The only significant X² related to specialty, with the geriatric specialty being over-represented. Patients in this specialty are known to require more physical care than patients in the other two. However, as will be seen below, that distribution of incidents did not hold good throughout the seven Sub-categories.

AREA C Category II Sub-category 1

"Monitors physical health of patient" (N = 39)

ABSTRACT (Eff. Sf.N. reporting on Self. Long St.)

"A patient looked distressed and complained of abdominal pain. The nurse examined the patient's abdomen and found it to be distended. A subsequent rectal examination established that the patient was constipated. I gave the patient an aperiant which enabled him to have a bowel movement."

ABSTRACT (Ineff. C.N. reporting on N.A. Ger.)

"A mildly demented chronic alcoholic patient continually demanded attention at inconvenient times of the day. She asked for a change of clothing but would not give a reason. The nurse did

not pay much attention at the time, she was used to receiving trivial complaints.

Later in the day it was discovered that the patient had bleeding haemorrhoids. The nurse should have questioned the patient closely, investigated the complaint and reported her findings to the senior nursing staff."

| <u>Shift</u> (N = 39) | | | <u>Specialty</u> (N = 39) | | | <u>Eff. Ineff.</u> (N = 39) | |
|-----------------------|-----------------------------|-----|-----------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 12 | 27 | 16 | 12 | 11 | 26 | 13 |
| E. | 13 | 26 | 23 | 9 | 7 | 24 | 15 |
| | (x ² = 0.1 N.S.) | | (x ² = 5.4 N.S.) | | | (x ² = 0.4 N.S.) | |

| <u>Staff reported on</u> (N = 54) | | | | | | |
|-----------------------------------|---------------------|-------|------|-------------------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 12 | 8 | 13 | 7 | 4 | 10 |
| | Patient respondents | | 1 | Other respondents | | 38 |

The x² detected no significant difference in the distribution of incidents between shift, specialty or effective-ineffective. The test could not be applied to staff reported on, but it is known that all staff were reported on with incidents relating to nursing assistants coming third in number after charge nurses and enrolled nurses.

AREA C Category II Sub-category 2

"Selects or initiates appropriate physical care" (N = 513)

ABSTRACT (Eff. N.A. reporting on Self. Ger.)

"At bedtime each patient is washed with special care being given to clean under their breasts and to their private parts. Their pressure areas are attended to and their backs and heels rubbed. This helps the patient to keep fresh and aids circulation.

ABSTRACT (Ineff. E.N. Reporting on C.N. Ger.)

"A patient required a urinal. The charge nurse went for one and put it on top of the patient's locker. The patient couldn't reach the urinal and this resulted in him urinating in the bed."

| <u>Shift</u> (N = 513) | | <u>Specialty</u> (N = 513) | | | <u>Eff. Ineff.</u> (N = 513) | |
|------------------------|--------------------------|----------------------------|-----------------------------|----------|------------------------------|-----------------------------|
| | Night | Day | Ger. | Long St. | Acute | Eff. Ineff. |
| O. | 137 | 376* | 322 | 117 | 74 | 324 189 |
| E. | 174 | 339 | 307 | 118 | 88 | 318 195 |
| | (X ² = 11.9S) | | (X ² = 2.9 N.S.) | | | (X ² = 0.3 N.S.) |

| <u>Staff reported on (N = 598)</u> | | | | | | |
|------------------------------------|-----------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 101 | 73 | 119 | 57 | 50 | 198 |
| E. | 95 | 74 | 126 | 59 | 46 | 198 |
| | (X ² = 1.2 N.S.) | | | | | |

Patient respondents 69 Other respondents 444

This Sub-category, containing 67% of incidents in the Category, was the largest Sub-category in the entire classification system. The X² detected no significant differences between specialties. Neither effective nor ineffective incidents were over-represented, and all staff grades were reported on with expected frequency. In relation to shift, the X² detected the emphasis to be on day shift incidents, with those relating to night shift consisting of 27% of the total. The shift emphasis is not surprising in view of the fact that the majority of physical care requirements are known to be met during the day-time hours.

AREA C Category II Sub-category 3

"Recognises personal limitations when delivering physical care" (N = 27)

ABSTRACT (Eff. N.A. reporting on N.A. Ger.)

"The nurse asked me to help her as the patient was very difficult and rigid. Had she not asked for help she would have had to struggle

on her own. This would have made the patient even more frightened and difficult to manage."

ABSTRACT (Ineff. St.N. reporting on Self. Acute)

"I was told to take charge of the recovery room during the electro-convulsive therapy sessions. A pupil nurse brought in the first patient. We managed to lift him on to the bed with a struggle, we should have had more help to lift the patient. I am sure the struggle did not do my back any good."

| <u>Shift</u> (N = 27) | | | <u>Specialty</u> (N = 27) | | | | <u>Eff. Ineff.</u> (N = 27) | |
|-----------------------|-------------------------|-----|-----------------------------|----------|-------|--|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | | Eff. | Ineff. |
| O. | 4 | 23* | 14 | 10 | 3 | | 11 | 16* |
| E. | 9 | 18 | 16 | 6 | 5 | | 17 | 10 |
| | (X ² = 4.2S) | | (X ² = 3.7 N.S.) | | | | (X ² = 5.7S) | |

| <u>Staff reported on</u> (N = 27) | | | | | | |
|-----------------------------------|------|-------|------|-------------------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 1 | 1 | 5 | 5 | 3 | 12 |
| Patient respondents | | | 0 | Other respondents | | |
| | | | | 27 | | |

The only significant X² in this Sub-category detected an over-representation of ineffective incidents. All staff grades were reported on with incidents relating to nursing assistants accounting for 44% of the total.

AREA C Category II Sub-category 4

"Is aware of patients' treatments, physical needs and care" (N = 28)

ABSTRACT (Eff. P.N. reporting on E.N. Ger.)

"The patient was prescribed daily baths because of a skin condition. The staff nurse carried out this treatment as prescribed and gave him a daily bath. This was effective because the treatment had to be continuous to be of value."

ABSTRACT (Ineff. Dr. reporting on C.N. Acute)

"An elderly depressed patient was recovering from a surgical repair of a fractured femur. After treatment in a general hospital she was returned here with the instruction that she gradually increase exercise and weight bearing. In her eagerness to get the patient 'going' the nurse was inclined to force the pace. She ignored the patient's complaints of pain, suggesting she was lazy. The charge nurse should have been more aware of the patient's treatment and abilities."

| <u>Shift</u> (N = 28) | | | <u>Specialty</u> (N = 28) | | | <u>Eff. Ineff.</u> (N = 28) | |
|-----------------------|--------------------------|-----|-----------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 1 | 27* | 16 | 5 | 7 | 7 | 21* |
| E. | 10 | 18 | 17 | 6 | 5 | 17 | 11 |
| | (X ² = 12.6S) | | (X ² = 1.0 N.S.) | | | (X ² = 14.9S) | |

| <u>Staff reported on (N = 28)</u> | | | | | | |
|-----------------------------------|---------------------|-------|------|-------------------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 5 | 1 | 3 | 5 | 3 | 11 |
| | Patient respondents | | 2 | Other respondents | | 26 |

Incidents related almost exclusively to day shift were not specialty specific and were predominantly ineffective. As with the previous Sub-category those relating to nursing assistants accounted for a large part (39%) of the total.

The relatively small number of incidents in this and the previous Sub-categories may reflect these activities being 'taken for granted'. That is, when they are performed well they are rarely commented on. However, a poor performance is immediately noticed, not least of all because of the overt and sometimes serious consequences.

AREA C Category II Sub-category 5

"Plans physical care or treatment in advance of it being delivered" (N = 10)

ABSTRACT (Eff. N.A. reporting on Self. Ger.)

"I prepared everything for the patients' daily shower, e.g. talc, soap, towels and face cloth. I laid out clean things for each

patient before I started with the shower."

ABSTRACT (Ineff. Dr. reporting on C.N. Acute)

"A patient fell and sustained a cut eye which required stitching. The nurse informed the doctor immediately and advised him that the cut required stitching. When the doctor arrived one hour later the nurse had failed to prepare any of the equipment necessary to repair the wound. The activity was ineffective because the lack of preparation by the nurse added to the time taken to close the wound."

| <u>Shift</u> (N = 10) | | | <u>Specialty</u> (N = 10) | | | | <u>Eff. Ineff.</u> (N = 10) | |
|-----------------------|-------|-----|---------------------------|----------|-------|--|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | | Eff. | Ineff. |
| O. | 2 | 8 | 6 | 2 | 2 | | 5 | 5 |

| <u>Staff reported on</u> (N = 10) | | | | | | |
|-----------------------------------|------|-------|------|-------------------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 2 | 3 | 1 | - | - | 4 |
| Patient respondents | | | 0 | Other respondents | | 10 |

The small number of incidents in this Sub-category prevented the application of an χ^2 . No further comment will be made.

AREA C Category II Sub-category 6

"Promotes sleep" (N = 91)

ABSTRACT (Eff. N.A. reporting on E.N. Ger.)

"A patient was having difficulty in falling asleep. She complained of being very cold and hungry. The nurse gave her a cup of hot tea, something to eat, put an extra blanket on her bed and filled a hot water bottle for her. The patient felt contented and cared for and fell asleep without any sedation."

ABSTRACT (Ineff. N.A. reporting on Sf.N. Ger.)

"The staff nurse went around the ward every five minutes and shone a torch on the patients to see if they were asleep. This was ineffective because it disturbed the patients."

| <u>Shift</u> (N = 91) | | | <u>Specialty</u> (N = 91) | | | <u>Eff. Ineff.</u> (N = 91) | |
|-----------------------|---------------------------|-----|-----------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 86* | 5 | 57 | 15 | 19 | 72* | 19 |
| E. | 31 | 60 | 54 | 21 | 16 | 56 | 35 |
| | (X ² = 147. S) | | (X ² = 2.4 N.S.) | | | (X ² = 11.8S) | |

| <u>Staff reported on</u> (N = 96) | | | | | | |
|-----------------------------------|--------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 9 | 12 | 33* | 1 | 3 | 38* |
| E. | 15 | 12 | 20 | 10 | 7 | 32 |
| | (X ² = 22.4S) | | | | | |

Patient respondents 9 Other respondents 82

As expected the vast majority (95%) of incidents relating to "Promotes sleep" referred to night shift, they were, however, not shift specific, and effective incidents were over-represented.

All staff grades were reported on with the X² detecting an emphasis on the enrolled nurse and nursing assistant grades. A few (4%) of the incidents related to nurses in training (St.N. and P.N.). The over-representation of the grades (E.N. and N.A.) may result from the preponderance of these grades on night shift.

AREA C Category II Sub-category 7

"Protects patients from a potentially dangerous environment.

Removes potentially harmful items from the environment."

(N = 53)

ABSTRACT (Eff. C.N. reporting on St.N. Acute)

"An elderly confused patient had wandered away from a nearby ward and out into the full force of a snow storm. The nurse intercepted the patient and encouraged him to return to the ward. The nurse had brought the patient out of the cold weather and prevented him from coming to considerable harm"

ABSTRACT (Ineff. E.N. reporting on Sf.N. Acute)

"The nurse was checking the stock in the drug cupboard when a potentially dangerous patient requested two pills for a headache. The nurse allowed the patient to enter the drug cupboard to receive

the medication. The patient succeeded in snatching a bottle of Valium and managed to swallow at least a dozen pills before the bottle could be removed from her. The activity was ineffective because you should not take chances and allow a patient into a cupboard containing drugs. The safety of the patient could be very much in danger."

| <u>Shift</u> (N = 53) | | <u>Specialty</u> (N = 53) | | | | <u>Eff. Ineff.</u> (N = 53) | |
|-----------------------|---------------------------|---------------------------|-----------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 17 | 36 | 24 | 15 | 14 | 26 | 27* |
| E. | 18 | 35 | 32 | 12 | 9 | 33 | 20 |
| | (X ² = 0 N.S.) | | (X ² = 5.5 N.S.) | | | (X ² = 3.9S) | |

| <u>Staff reported on (N = 58)</u> | | | | | | |
|-----------------------------------|---------------------|-------|------|-------------------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 9 | 10 | 10 | 11 | 3 | 15 |
| | Patient respondents | | 1 | Other respondents | | 52 |

This activity was not found to be shift or specialty specific, with all grades being reported on. The only significant X² result detected on over-representation of ineffective incidents. Clearly the high visibility nature of, and results from, not protecting patients from a dangerous environment may have caused the over-representation of ineffective incidents.

Summary of incidents in AREA C, "PROVIDES, PLANS FOR, OR MONITORS PHYSICAL CARE", Category II, "Gives Physical Care", Sub-categories 1 - 7

Shift

For Category II as a whole there was no significant difference in the distribution of incidents between shifts. Data in six Sub-categories was subjected to the X² test with the following results;

Night shift over-represented ; 1 Sub-category
 Day shift over-represented ; 3 Sub-categories
 No differences between shifts ; 2 Sub-categories

The one Sub-category in which night shift was emphasised related to promoting sleep. The two in which day shift were emphasised related to delivery of physical care, other than promoting sleep or an awareness of patients' physical needs.

Specialty

At Category level the geriatric specialty was over-represented. However, the six X^2 tests performed at Sub-category level detected no Specialty emphasis.

Effective-Ineffective Incidents

At Category level there was no significant difference in the distribution of incidents between Eff. and Ineff., however this did not hold good throughout the Sub-categories. The X^2 that was applied on six occasions with the following results:

| | | |
|--------------------------------------|---|------------------|
| No significant Eff.-Ineff. emphasis | ; | 2 Sub-categories |
| Effective incidents over-represented | ; | 1 Sub-category |
| Ineffective " . " " | ; | 3 Sub-categories |

Staff reported on

At Category level there was no significant difference in the distribution of incidents between staff grades although it was found that all three qualified staff grades (C.N., Sf.N., and E.N.) were under-represented.

Two X^2 tests were carried out with the following results:

| | | |
|--|---|----------------|
| No significant difference between grades | ; | 1 Sub-category |
| Significant difference between grades | ; | 1 Sub-category |

The positive X^2 detected an over-representation of the enrolled nurse and nursing assistant grades.

AREA D "PERSONNEL FUNCTION" (N = 302)

ABSTRACT (Eff. N.O. reporting on C.N. Acute)

"The patients in the acute ward were very disturbed and required constant close supervision. This was putting a great strain on the limited number of staff available. The nurse reported the situation to the nursing officer who was able to increase the staffing level over the difficult period. The activity was effective because it enabled appropriate action to be taken immediately."

ABSTRACT (Ineff. St.N. reporting on C.N. Ger.)

"The charge nurse drinks openly and never gets reprimanded. She is often drunk on duty, is irresponsible, sets a bad example and cannot cope with the ward situation. This is ineffective because although she holds a responsible position in the hospital she is not capable of doing the job."

| | <u>Shift</u> (N = 302) | | <u>Specialty</u> (N = 302) | | | <u>Eff. Ineff.</u> (N = 302) | |
|----|-----------------------------|-----|-----------------------------|----------|-------|------------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 59 | 243 | 126 | 91 | 85 | 101 | 201* |
| E. | 63 | 239 | 113 | 100 | 89 | 176 | 126 |
| | (x ² = 0.3 N.S.) | | (x ² = 2.4 N.S.) | | | (x ² = 76.6S) | |

| | <u>Staff reported on</u> (N = 332) | | | | | |
|----|------------------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 142* | 33 | 52 | 34 | 15 | 56 |
| E. | 85 | 45 | 66 | 38 | 25 | 73 |
| | (x ² = 52.8S) | | | | | |

Patient respondents 0 Other respondents 302

The x² was applied to all four data categorisation at AREA level. It demonstrated the absence of a shift or specialty emphasis. However, the test did detect an over-representation of ineffective incidents and a biased distribution between staff reported on in favour of the charge nurse grade. Although all staff grades were reported on the charge nurse grade was the only one reported on more frequently than expected and accounted for 43% of the incidents. The frequency with which the charge nurse was

reported on was not unexpected in view of his key role as the controller of staff and team leader within his ward.

The emphasis on ineffective incidents at AREA level is atypical in that the emphasis at the three other AREA levels was on effective incidents. However, the over-representation of ineffective incidents at Category level may indicate a general difficulty which nurses have in relation to "PERSONNEL FUNCTION".

No incidents in Area D were provided by patients.

AREA D Category I "Maximises Staff Contribution" (N = 211)

ABSTRACT (Eff. E.N. reporting on C.N. Long St.)

"A new nurse started work in the ward. She was very apprehensive about psychiatric nursing. The charge nurse took the new nurse around the ward and introduced her to patients and staff and gave her an orientation to the different parts of the ward. By his action the charge nurse reduced the fear and apprehension which the new nurse had. He also established a contact between himself and a new member of his staff."

ABSTRACT (Ineff. C.N. reporting on N.A. Long St.)

"Twelve patients were eating lunch, three nursing assistants were serving food and clearing dishes. One nurse stood back and appeared to leave the two other nurses to do most of the work. This caused resentment amongst other staff and the patients did not receive all the available care and assistance from the available manpower in the ward."

| <u>Shift</u> (N = 211) | | | <u>Specialty</u> (N = 211) | | | <u>Eff. Ineff.</u> (N = 211) | |
|------------------------|-----------------------------|-----|----------------------------|----------|-------|------------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 50 | 161 | 103* | 67 | 41 | 42 | 169 |
| E. | 41 | 170 | 88 | 64 | 59 | 71 | 140 |
| | (X ² = 2.4 N.S.) | | (X ² = 8.2S) | | | (X ² = 17.8S) | |

| <u>Staff reported on</u> (N = 241) | | | | | | |
|------------------------------------|-----------------------------|-------|------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 91 | 27 | 41 | 21 | 12 | 49 |
| E. | 103 | 24 | 38 | 25 | 10 | 41 |
| | (X ² = 4.6 N.S.) | | | | | |

Patient respondents 0 Other respondents 211

Category I was the largest of the two Categories in AREA D and contained 70% of the incidents. As with the Area generally, ineffective incidents were over emphasised, but the other three χ^2 tests gave different results. The geriatric specialty incidents predominated, there being no differences between staff reported on. The specialty emphasis may reflect the relatively low staffing levels in that work situation. Any instance of a nurse not maximising staff contribution is more obvious and worthy of comment and may account for the over-representation of ineffective incidents.

AREA D Category I Sub-category 1

"Encourages, accepts and uses staff suggestions.

Discusses proposed changes with staff" (N = 15)

ABSTRACT (Eff. E.N. reporting on C.N. Long St.)

"Following promotion to charge nurse grade, and being allocated to a new ward, he initiated ward meetings where all grades could sit and discuss how the ward could be better organised. Although he did not take kindly to the resulting confrontations, he now realises that it was for the best. He now feels more confident in his handling of the ward and all staff have benefitted from the meetings."

ABSTRACT (Ineff. C.N. reporting on Self. Long St.)

"I reorganised an off-duty rota for all staff without giving them reasons for the change or an explanation of what the changes were. The staff became annoyed and suggested that a little thought and time could have avoided unnecessary upheaval."

| <u>Shift</u> (N = 15) | | | <u>Specialty</u> (N = 15) | | | <u>Eff. Ineff.</u> (N = 15) | |
|-----------------------|-------|-----|---------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 0 | 15 | 4 | 7 | 4 | 10 | 5 |

| <u>Staff reported on</u> (N = 15) | | | | | | |
|-----------------------------------|------|-------|------|-------------------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 12 | 1 | 2 | - | - | - |
| Patient respondents | | | 0 | Other respondents | | |
| | | | | 15 | | |

The χ^2 was not applied to data in this Sub-category. However, it can be seen that the vast majority of incidents apply to day shift (100%) and the charge nurse grade (80%).

The day shift emphasis may result from the greater numbers and organisational complexity of the staff group on that shift compared with the night shift when one or two staff may work in a patient area. The charge nurse emphasis almost certainly results from his position as team leader and controller of many ward policies.

AREA D Category I Sub-category 2

"Arranges workload or work routine to maximise staff effectiveness and/or patient care" (N = 47)

ABSTRACT (Eff. N.O. reporting on C.N. Long St.)

"At the beginning of the day shift the ward duties were planned. The charge nurse delegated duties to all members of the staff, all members of staff then knew what their duties were."

ABSTRACT (Ineff. E.N. reporting on C.N. Acute)

"The medicine round usually started at 9.15 am after the patients had had their breakfast. The charge nurse decided to start the medicine round at 7.30 am to avoid clashing with the doctor's round which started at 9.30 am. This was ineffective because the patients were, in some cases, having doses of sedation before having something to eat. This resulted in some patients being unable to finish their breakfast or falling asleep over it."

| | <u>Shift</u> (N = 47) | | <u>Specialty</u> (N = 47) | | | <u>Eff. Ineff.</u> (N = 47) | |
|----|-------------------------------|-----|-------------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 11 | 36 | 23 | 15 | 9 | 19* | 28 |
| E. | 10 | 37 | 22 | 15 | 10 | 9 | 38 |
| | $(\chi^2 = 0.1 \text{ N.S.})$ | | $(\chi^2 = 0.1 \text{ N.S.})$ | | | $(\chi^2 = 13.7\text{s})$ | |

| <u>Staff reported on (N = 67)</u> | | | | | | |
|-----------------------------------|------|-------|------|-------------------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 25 | 9 | 11 | 7 | 5 | 10 |
| Patient respondents | | | 0 | Other respondents | | |
| | | | | 47 | | |

Incidents in Sub-category 2 were neither shift or specialty specific. Effective incidents predominated and seemed to reflect the considerable contribution which could be made to staff "output" by good quality arrangement of workload or ward routine.

The χ^2 was not applied to staff reported on but it can be seen that all staff grades were included.

AREA D Category I Sub-category 3

"Makes optimum use of personal skills, encourages others to do so" (N = 107)

ABSTRACT (Eff. N.O. reporting on C.N. Ger.)

"Weekly meetings took place between myself and the four charge nurses in my Unit. Much "lip service" was paid to the idea of the unit meeting, but the charge nurses put forward very few constructive ideas. A new charge nurse joined the unit staff. He made his ideas known and was prepared to challenge statements. This resulted in all of us learning to function as a more effective team. We were more able to explore the needs of the hospital and patients."

ABSTRACT (Ineff. N.O. reporting on P.N. Ger.)

"We were short of staff and a pupil nurse had been asked to work overtime. She failed to come on duty to work the overtime and failed to telephone or send any message of explanation. This resulted in staff from another ward having to be moved to cover the absence of the pupil nurse."

| <u>Shift</u> (N = 107) | | | <u>Specialty</u> (N = 107) | | | <u>Eff. Ineff.</u> (N = 107) | |
|------------------------|------------------------|-----|----------------------------|----------|-------|------------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 21 | 86 | 46 | 38 | 23 | 8 | 99* |
| E. | 25 | 82 | 52 | 34 | 21 | 21 | 86 |
| | ($\chi^2 = 0.8$ N.S.) | | ($\chi^2 = 1.2$ N.S.) | | | ($\chi^2 = 10.05$) | |

Staff reported on (N = 112)

| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
|----|------|-------|------|-------|------|------|
| O. | 29 | 13 | 23 | 13 | 7 | 27 |
| E. | 42 | 12 | 19 | 10 | 6 | 23 |

$(X^2 = 6.7 \text{ N.S.})$

Patient respondents 0 Other respondents 107

As with the AREA as a whole, incidents in this Sub-category were neither shift nor specialty specific, and the emphasis was on ineffective incidents.

The X^2 detected no significant difference in the distribution of incidents between staff reported on, all grades being included.

AREA D Category I Sub-category 4

"Reports on staff changes or shortages to senior staff and/or ensures adequate numbers of nursing staff." (N = 42)

ABSTRACT (Eff. Sf.N. reporting on Self. Ger.)

"When I came on duty I found there was no junior nurse on duty. I telephoned the night charge nurse to report the staff shortage. A nurse was sent to the ward."

ABSTRACT (Ineff. P.N. reporting on C.N. Ger.)

"There are around 80 - 90 patients in this ward. We only have a maximum for five staff to care for these patients. The patients will get their basic needs seen to, nothing else. You can't talk to the patients, you haven't got the time. It is ineffective having such large wards with so few staff to cover them, the charge nurse should take steps to have the staffing levels increased."

| <u>Shift</u> (N = 42) | | <u>Specialty</u> (N = 42) | | | <u>Eff. Ineff.</u> (N = 42) | |
|-----------------------|-----------------|---------------------------|----------------------------|----------|-----------------------------|----------------------------|
| | Night | Day | Ger. | Long St. | Acute | Eff. Ineff. |
| O. | 19* | 23 | 26 | 11 | 5 | 5 37 |
| E. | 10 | 32 | 20 | 13 | 9 | 8 34 |
| | $(X^2 = 10.6S)$ | | $(X^2 = 3.8 \text{ N.S.})$ | | | $(X^2 = 1.4 \text{ N.S.})$ |

| <u>Staff reported on (N = 47)</u> | | | | | |
|-----------------------------------|-------|------|-------------------|------|------|
| C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| 24 | 4 | 5 | 1 | 1 | 12 |
| Patient respondents | | 0 | Other respondents | | 42 |

Incidents in Sub-category were not specialty specific and were distributed between effective-ineffective as expected. The shift emphasis was on night shift where it is known that staffing levels tend to be at a minimum with the absence of even one nurse often constituting a crisis. Although all grades were reported on, 51% of the incidents related to the charge nurse, possibly underlining his key role as staff organiser.

Summary of incidents in AREA D "PERSONNEL FUNCTION", Category I
"Maximises Staff Contribution", Sub-categories 1 - 4.

Shift

For the Category as a whole no significant difference between shifts was detected, this held true in two of the three Sub-categories to which the X^2 was applied. Night shift incidents were over-represented in relation to Sub-category 4 "Reports on staff changes or shortages to senior staff and/or ensures adequate numbers of nursing staff". This over-representation may reflect the extremely low staffing levels which are known to exist on the night shift, increasing the urgency with which staff shortages must be reported and rectified.

Specialty

At Category level the X^2 detected a geriatric specialty emphasis, however, no significant X^2 results were found at Sub-category level.

Effective-Ineffective Incidents

The ineffective emphasis at Category level did not hold good throughout. The X^2 was applied to three Sub-categories with the

following results;

| | |
|-------------------------------------|------------------|
| No significant Eff.-Ineff. emphasis | ; 1 Sub-category |
| Eff. incidents over-represented | ; 1 Sub-category |
| Ineff. incidents over-represented | ; 1 Sub-category |

Staff reported on

At Category level the X^2 detected no significant difference in relation to staff reported on, that being confirmed in the one Sub-category (3) to which the test was applied.

AREA D Category II "Teaches, Counsels Or Gives Orientation To Staff"
(N = 91)

ABSTRACT (Eff. N.A. reporting on C.N. Ger.)

"When I first came to work in a psychiatric hospital I was very nervous as to what the patients and staff would be like. It was my first day and I was sure I would be a nuisance to the other members of staff.

The charge nurse took me around the ward and introduced me to various other members of staff. He chatted to me and explained about the routine of the ward and told me about the patients. This helped me to get over my nervousness and to feel less lost and hopeless. I felt I could ask questions and get an explanation."

ABSTRACT (Ineff. St.N. reporting on C.N. Long St.)

"This was my first time on a psychiatric ward. I did not know about mental illness and expected to be taught a little about it. So far nothing has been explained.

I was given no instruction or explanation regarding the patients and yet I was expected to look after and care for them without understanding their moods or behaviour. This was ineffective

because I do not fully understand the attitude to take to each individual patient."

| <u>Shift</u> (N = 91) | | <u>Specialty</u> (N = 91) | | | <u>Eff. Ineff.</u> (N = 91) | |
|-----------------------|-------------------------|---------------------------|--------------------------|----------|-----------------------------|--------------------------|
| | Night | Day | Ger. | Long St. | Acute | Eff. Ineff. |
| O. | 9 | 82* | 23 | 24 | 44* | 59* 32 |
| E. | 18 | 73 | 38 | 27 | 26 | 30 61 |
| | (x ² = 5.6S) | | (x ² = 18.7S) | | | (x ² = 41.8S) |

| <u>Staff reported on</u> (N = 91) | | | | | | |
|-----------------------------------|-----------------------|-------|----------------------|-------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 51 | 6 | 11 | 13 | 3 | 7 |
| | Patient respondents 0 | | Other respondents 91 | | | |

The day shift emphasis probably results from the limited opportunity for teaching to take place during night time due to a low level of staffing (sometimes one nurse per ward) and the infrequency with which "learners" (St.N.'s and P.N.'s) work on night shift. However, this explanation poses the question, "who teaches those who are on night shift?" and how do they obtain the experience necessary to teach?

The emphasis of the acute specialty may result from relatively high staffing levels and from the tendency for learners (St.N.'s and P.N.'s) to spend longer periods of time there.

The considerable emphasis on effective incidents is contrary to that found at AREA level, and in relation to Category I. The effective emphasis could be explained by accepting that nurses do not expect to be taught, counselled or given orientation. Thus, when it fails to occur, it passes without comment; when it is done the outcome tends to be effective and worthy of comment.

No x² test was applied to staff reported on, however, it can be seen that all grades were included. Student nurses, one of the two "learner" grades, were reported on more often than two of the qualified nurse grades (Sf.N.'s and E.N.'s) who have a formal teaching, counselling and orientation function. Similarly nursing assistants, the only grade who have not and will not have a formal nurse training were reported on more frequently than the staff nurse grade.

AREA D Category II Sub-category 1

"Teaches, counsels or gives orientation to staff" (N = 91)

ABSTRACT (Eff. C.N. reporting on Self. Long St.)

"While giving a work report to a junior nurse I discussed it in detail with her. This had not been done before and it revealed to the nurse, and myself, that she did not understand some of the items in the report. In the past she had just accepted the ward reports without really thinking about it or why she had been given particular grades."

ABSTRACT (Ineff. Sf.N. reporting on Self. Ger.)

"A new nursing assistant was helping me to perform the last offices on a recently deceased patient. I left the nurse for a few minutes, giving her a poor explanation of what was to be done with the body. When I got back the nurse was wearing the shroud and the patient was exposed."

| <u>Shift</u> (N = 91) | | | <u>Specialty</u> (N = 91) | | | <u>Eff. Ineff.</u> (N = 91) | |
|-----------------------|---------------------------|-----|---------------------------|----------|-------|-----------------------------|--------|
| | Night | Day | Ger. | Long St. | Acute | Eff. | Ineff. |
| O. | 9 | 82 | 23 | 24 | 44 | 59 | 32 |
| E. | 9 | 82 | 23 | 24 | 44 | 59 | 32 |
| | (X ² = 0 N.S.) | | (X ² = 0 N.S.) | | | (X ² = 0 N.S.) | |

| <u>Staff reported on</u> (N = 91) | | | | | | |
|-----------------------------------|---------------------|-------|------|-------------------|------|------|
| | C.N. | Sf.N. | E.N. | St.N. | P.N. | N.A. |
| O. | 51 | 6 | 11 | 13 | 3 | 7 |
| | Patient respondents | | 0 | Other respondents | | 91 |

Summary of distribution of incidents within AREA D,

Category II, Sub-category 1 "Teaches, counsels or gives orientation to staff"

No summary is necessary in view of the Category containing only one Sub-category.

Possible further data analysis

While the analysis of data in this chapter has been related to achieving the objectives of this study, it is recognised that further analysis may help to clarify further some of the issues raised. It is recognised that any future extension of this research would benefit from additional data analyses such as those described below.

For example, it is possible that while differences did not emerge for shifts and specialties separately, there could be differences between specialties within shifts. Thus, multi-dimensional analysis may produce interaction effects among the variables studied, which might modify the overall conclusions of no differences arrived at here.

Also, there were obvious differences in the numbers of incidents provided by patient and other respondents in some of the AREAS, Categories and Sub-categories. Analysis of these may indicate that there are important differences between patient and non-patient perceptions of what is important or effective in nursing, a factor which would also need to be considered when, for example, attempting to establish priorities in nurse education.

This further data analysis might be done as follows:

In relation to one shift, day shift, a χ^2 test may be applied to examine the distribution of incidents between:

| | | |
|---------------------------------|---|-------|
| Specialty | X | 3 |
| Effective-Ineffective incidents | X | 2 |
| Grade of nurse reported on | X | 6 |
| Patient-other respondents | X | 2 |
| | | <hr/> |
| | | 13 |

Such an analysis could be applied to each AREA, Category and Sub-category containing large enough numbers of critical incidents to enable application of the χ^2 .

To illustrate the application of the above two possible types of data analysis, one example of each will be presented below.

a) Patient-other respondent

The distribution of critical incidents between patient and other respondents can be examined using the χ^2 with one degree of freedom. The χ^2 can be applied only when the number in the EXPECTED OUTCOME cell is not less than 5.

The expected distribution can be derived from the percentage distribution of items in the next highest level in the three tier classification system. For example, the distribution of incidents between "patient" and "other" respondents in the whole data were as follows:

| <u>Patient respondents</u> | <u>Other respondents</u> |
|----------------------------|--------------------------|
| 16.53% | 83.47% |

Thus the EXPECTED FREQUENCY for the distribution of incidents between respondents in each of the four AREAS became 16.53% for "patient" respondents and 83.47% for "other" respondents.

With this type of analysis the activity in which patient respondents were over-represented in AREA is examined.

Distribution of incidents between "patient" and "other" respondents (N = 4477) o = observed frequency
e = expected frequency

| | Patient respondents (P) | Other respondents (O) |
|------------------------|-------------------------|-----------------------|
| All critical incidents | 740 (16.53%) | 3737 (83.47%) |

AREA

| A | "STAFF INITIATED THERAPEUTIC INTERVENTION" | |
|----|--|------|
| | P. | O. |
| o. | 584* | 2626 |
| e. | 531 | 2679 |
| | $\chi^2 = 6.34$ S | |

The χ^2 result is significant at 1 d.f.; the over-represented respondent group is indicated with an asterisk (*). In relation to AREA A "STAFF INITIATED THERAPEUTIC INTERVENTION" responses from patients were greater than expected. That patient responses should be over-represented in one of the two AREAS (A and C) with an overt and direct relevance for patient care may not be surprising. Patients tend to be less directly involved in and less aware of the subjects of the other two AREAS (B and D)

which relate to administrative and personnel functions respectively. The χ^2 also detected an over-representation of incidents relating to the long stay and acute specialties relating to AREA A, these two specialties being those from which patient respondents were drawn. The dominance of patient respondents in AREA A may reflect the subject of this AREA being a focus of patient concern relative to the other three AREAS. Alternatively it may reflect the fact that patient respondents, drawn from the acute and long stay specialties, are over-represented because AREA A tends to be specialty specific in favour of these two patient groups.

The outcome of this type of analysis may, for example, be used in relation to the establishment of nursing priorities from a patient viewpoint and could, with yet further analysis help identify the nursing activities which patients view as being effective or ineffective. While it is not being argued that such an examination of the data will produce a definitive answer to the question "what is the role of the psychiatric nurse, and what are the priorities of nursing education?", such analysis could well add an important dimension to examination of these questions.

b) Multidimensional analysis of data (Specialty differences relating to night shift)

For AREA A as a whole "STAFF INITIATED THERAPEUTIC INTERVENTION" the 3210 critical incidents were distributed in favour of the long stay and acute specialties ($\chi^2 = 33.75$ at 2 d.f.) However, this type of analysis fails to detect any specialty difference which may exist within night shift and day shift when considered separately.

The expected distribution between specialties within AREA, and for night shift only can be derived from the specialty distribution for night shift at the next highest level in the three tier classification system. For example, the distribution of night shift incidents between specialties for the whole data were as follows:

| Shift (N = 930) | | Specialties (N = 930) | | |
|-----------------|----------|-----------------------|----------|--|
| Night shift | Ger. | Long St. | Acute | |
| | 456 | 224 | 250 | |
| | (49.03%) | (24.09%) | (26.88%) | |

Using the above distribution of all night shift incidents between specialties to determine EXPECTED FREQUENCY of distribution at AREA level, the χ^2 may be applied with the following result.

AREA A "STAFF INITIATED THERAPEUTIC INTERVENTION"

| Night Shift | | Specialty (N = 570) | | |
|-------------|----|---------------------|----------|-------|
| (N = 570) | | Ger. | Long St. | Acute |
| | o. | 241 | 146* | 183* |
| | e. | 280 | 137 | 153 |

$\chi^2 = 11.9$ and is significant at 2 d.f. and the over-represented specialties are marked with an asterisk (*). This result confirms that incidents in AREA A which are specialty specific for day and night shift combined (See p 88) are also specialty specific for night shift alone. However, such an examination of the data could have demonstrated the absence of, or a different, distribution of incidents between specialties when shifts are tested separately.

The outcome of such an analysis could serve to refine and, possibly, modify, the general conclusions of this study. For example, data in this work were examined to determine if the role of each of the six ward based staff grades differed in relation to night shift and day shift combined. Clearly, the outcome of such an analysis may be different when the role of the nurse is examined in relation to day shift and night shift separately. Further similar analyses, using a multi-dimensional approach, would allow conclusions to be drawn about how correlations of the different variables used in the study interact.

DATA ANALYSIS (DOCUMENTARY DATA)

The following section relates to what nurses in the study are trained to do, what their job descriptions are, and the criteria on which their nursing performance is assessed. Although the present discussion does not include what nurses actually do, it will be assumed that job training should equip nurses for what they are expected to do as described in their job description which should contain a description of what nurses actually do. This, in turn, should be reflected in the content of the nurse's job assessment which should reflect the nurses'

- (i) Job training
- (ii) Job description and
- (iii) Actual job.

If the role of a nurse in one grade is different to that of a nurse in another grade then their training, job description and assessment criteria should reflect that difference. Conversely if a nurse in one grade has a different training, job description or assessment criteria to that of another nurse their actual job content should be different.

Job Training The six grades of nurses described in this study have undergone, or are undergoing, one of three types of training. The content of the training will be discussed later, however it will be described in general terms here.

(i) Nursing assistant This grade of nurse received an "inservice" type of training which typically takes place in a classroom setting in the hospital employing the nurse. This may, or may not, continue formally during the subsequent work experience of the nurse. There is no formal examination associated with nursing assistant training, the quality and quantity of which may vary considerably between hospitals.

(ii) Pupil nurse This grade undergo a two year course of training which is not specialty specific. The same training programme is undergone by nurses irrespective of whether they are intending to work in any of the four specialties: General Nursing, Sick Children's Nursing, Psychiatric Nursing and Mental Deficiency Nursing.

The two year pupil nurse training is prescribed and monitored by the General Nursing Council for Scotland who determine the distribution of time between classroom and practical activity. They also prepare the syllabus of training and maintain a roll of nurses who hold this qualification. On qualifying, pupil nurses become an

(iii) Enrolled nurse No further training is required. Training as a pupil nurse enables the individual to become an enrolled nurse.

(iv) Student nurse This grade undergo a three year course of training which is specialty specific. Either before, or in a few instances during, training the nurse chooses to specialise in one of four specialties; General Nursing, Sick Children Nursing, Psychiatric Nursing or Mental Deficiency Nursing. Student nurses in this study had opted for a training related to Psychiatric Nursing.

The three year student nursing training is prescribed and monitored by the General Nursing Council for Scotland who determine the distribution of time between classroom and practical activity. They also prepare the syllabus of training and maintain a register of nurses who have successfully completed the course. On qualifying, student nurses become Registered Mental Nurses who are eligible to hold the post of

(v) Staff nurse No further training is required. Training as a student nurse enables the individual to become a Registered Mental Nurse and work as a staff nurse in a psychiatric hospital. Staff nurses may apply for promotion to the grade of

(vi) Charge nurse No further training is required.
The training required to become a charge nurse is that undergone by the student nurse.

Job Description

A report by the Ministry of Health, and the Scottish Home and Health Department (1966) provided the impetus for the use of job descriptions in nursing, and described them as being:

"..... the description of a job as a result of job analysis" p 119

which they describe as being:

"the study of a job by breaking it down into its tasks, processes and operations" p 119

The job descriptions provided in the report are

"to be regarded as guides. They are not complete for every job but they can be used as models." p 8

The job descriptions contained in the report relate to only one of the nurse grades studied in this paper, the charge nurse, but other grades have subsequently been given job descriptions by their employers.

Typically a job description contains the following:

- (i) The grade of the nurse.
- (ii) To whom the nurse is responsible.
- (iii) Minimal qualifications required (if any).
- (iv) Functions or duties of the nurse.

Assessment In the past ten years nurses have been increasingly undergoing written assessment of their performance. Typically, in the case of ward based nursing staff, this is done annually by the charge nurse, the nursing officer assessing the charge nurse. Pupil and student nurses are assessed by the charge nurse in consultation with other ward based trained staff at the end of each period of ward experience.

The job training, description and assessment applied to each of the above six grades will be considered in turn. Data on which the description and discussion are based were obtained from the hospitals from which critical incidents were collected. Eleven

hospitals agreed to allow the writer to collect critical incidents, each being asked to provide copies of job training, job description and job assessment. A small number of hospitals were unable to provide all requested documents for one of three reasons. Either because copies were not available, or because revised documents were in the process of being prepared, or because the documents did not exist.

Nursing assistant (Job Training, Description and Assessment)

Training (Seven hospitals provided training programmes)

All items on the nursing assistant training programmes obtained related to the provision of physical nursing care or, in a small number of instances, administrative aspects of care such as reporting of accidents.

A typical arrangement for training nursing assistants was on an "in-service" basis, the nurse attending a series of one-day classroom sessions, or a one-week period of classroom study. In principle, this period of classroom experience was supplemented by on-going education added to, and resulting from, working under the supervision of trained nursing staff. Appendix 12 is an example of the most comprehensive nursing assistant training programme given to the writer, each item being demonstrated, discussed with and practiced with the nursing assistant. When proficiency was achieved, the supervising trained nurse placed a date and signature against the item.

None of the training programmes made specific reference to non-physical aspects of patient care. In short, the nursing assistant was being trained to provide physical care only.

Job Description (Nine hospitals provided job descriptions)

The job descriptions obtained for nursing assistants were all virtually identical and were based on advice contained in the Scottish Home and Health Department circular S.H.M. 70/1970.

As with the training programme, the job description related almost exclusively to physical aspects of care, for example "assisting with care of pressure areas", and made no explicit reference to non-physical aspects of care (See Appendix 13 for an example). Two features of the document are worthy of special mention; first, the role of the nursing assistant, as it relates to direct patient care, is largely to assist other staff. Second, the job description generally contains specific items relating to patient care, for example, "assisting with care of pressure areas". The specific content of the job description is to be contrasted with that of the job descriptions of other grades (see below).

Assessment (Ten hospitals provided assessment forms)

The assessment forms for this grade tended to be both brief and vague in comparison to the documents relating to job description and training. The example in Appendix 14 contains twelve items, none of which related specifically to physical care. The lack of specificity is reflected in the items such as "Attitude towards patients", "Reliability", and "Professional interest".

Summary of nursing assistant job training, job description and assessment.

The documents obtained presented a picture of the training and job of the nursing assistant as relating to assisting trained nurses with the physical care of patients. The assessment of this nurse grade lacked the specificity, or reference to physical care, which were features of both the training and job descriptions.

Pupil Nurse (Job Training, Description and Assessment)

Training All (eleven) hospitals provided documents.

The General Nursing Council for Scotland (1973) prescribe and monitor the training content for the pupil nurse grade. The training lasts two years and is biased in favour of a practical and physical

care type of experience (See Appendix 15 for the pupil nurse training programme).

The elements of the training programme for the pupil nurse grade were both physical illness orientated, and lacking in specificity. Personal correspondence from a senior nurse tutor indicated that the pupil nurse grade may receive as little as five hours classroom instruction relating to non-physical illness and related nursing care.

Job Descriptions (These do not exist, see below)

Job descriptions for pupil nurses do not exist, they are training to do a job rather than doing it.

The job which they are training to do is that of an enrolled nurse whose job description can be found below (See Appendix 17).

Assessment (All (eleven) hospitals provided forms)

All hospitals used similar, or identical, forms which were used for the assessment of both pupil and student nurses. Although the forms used to assess pupil and student nurses were more comprehensive than those used to assess other staff grades, they were not specific in relation to individual elements of assessment (See Appendix 16). The extent to which they related to the training content for pupil nurses were minimal. For example the nurse is assessed in relation to;

"Uses opportunities to guide and instruct patients/
co-workers/relatives."

but this item does not form part of the pupil nurse syllabus of training.

Summary of pupil nurse job training, job description and assessment.

The elements of the training programme for the pupil nurse grade were both specific and physical care orientated. Assessment, which was invariably identical to that of the student nurse, emphasised personal qualities and tended to lack specificity. The assessment element did not clearly reflect job training elements.

Enrolled nurse (Job Training, Description and Assessment)

Training (All (eleven) hospitals provided documents)

The training for the enrolled nurse grade is that which is undergone by the pupil nurse grade (See Appendix 15).

Job Description (Nine hospitals provided forms)

Job descriptions for this grade were almost identical to those for the staff nurse and charge nurse grades. As with the job descriptions for these other two grades, those for the enrolled nurse tended to lack specificity. The other major feature was that elements of the job description implied that the enrolled nurse had a largely "assisting" function (See Appendix 17). An example of this "assisting" function is;

"Assisting registered nurses in the teaching of students and pupils"

Assessment (Eight hospitals provided forms)

Seven hospitals used the same form to assess enrolled nurses, charge nurses and staff nurses. The eighth hospital used a slightly different form to assess each of the above three grades.

The enrolled nurse assessment form did not reflect that grade's training programme or job description. References to specific areas are minimal (See Appendix 18) and individual elements tend to be vague. Examples are: "Exercise of judgement" and "Degree of initiative" and "Performance of Duties".

Summary of enrolled nurse training, job description and assessment.

The elements of the training programme of this grade related largely to physical care and were relatively specific. Job descriptions were identical, or near identical, to those of charge nurses and staff nurses. Neither the job descriptions, or assessment forms, reflected the training content.

Student Nurse (Job Training, Description and Assessment)

The General Nursing Council for Scotland (1973) prescribe and monitor the training content for the student nurse grade. Training lasts three years with the distribution of time between practical and theoretical activity as follows:

TABLE 17

| Distribution of Total Training Time for Student Nurses (Cormack 1975) | | |
|--|-----------|-----------------------|
| | | % Total Training Time |
| Practical Training (Clinical Work) | 4944 hrs. | 85.83% |
| Unallocated Theory Time | 305 hrs. | 5.3% |
| Allocated Theory Time | 511 hrs. | 8.87% |
| Total Training Time | 5760 hrs. | 100.00% |

Cormack (1975) echoed the concerns of a number of writers who were disturbed with the emphasis of physical disease and associated nursing care. Maddox (1957) explained the over emphasis on physical aspects of illness thus;

"Since the war deliberate attempts have been made to raise the status of mental nurses, and as general nursing is more highly regarded in the community there have been attempts to introduce the standards and practices of general nursing into mental nursing." p 190

The syllabus of training for the student nurse grade (See Appendix 19) reflects a considerable emphasis on physical illness and associated nursing care, these areas tending to be relatively specific. Examples are "Care of pressure areas", "Preparing and serving meals" and "Gastric lavage".

The area devoted to Advanced Nursing/Psychiatric Nursing is less specific and relates to subjects such as; "Team nursing" and special nursing care of the "obstreperous patient", the "dangerously ill patient" and the "convalescent patient".

The specialist training given to the student nurse, preparing him to care for the mentally ill, is specific and biased in relation to physical illness and care. Elements relating to non-physical care tend to be in the minority and lacking in specificity.

Job Description (These do not exist, see below)

Job descriptions for student nurses do not exist, they are training to do a job, rather than doing it.

The job which they are training to do is that of staff nurse whose job description is described below (See Appendix 20).

Assessment (All (eleven) hospitals provided forms)

All hospitals used identical or similar forms for the assessment of both student and pupil nurses. The assessment form content did not reflect the training programme content, it also tended to be vague for example;

"Demonstrates an appropriate degree of initiative and self-reliance."

See Appendix 16 for a complete student nurse assessment form.

Summary of the student nurse training, job description and assessment.

The elements of the training programme for student nurses were specific in relation to physical illness and care, which it emphasised. It was more detailed and contained a width and depth greater than that in the pupil nurse training programme. Reference to non physical care was relatively limited and lacked specific detail. The considerable differences in the training programmes for student and pupil nurses were not reflected in the assessment forms which were identical. Also, the differences in training programmes were not reflected in the near identical job descriptions which will be used by both grades on completing training.

Staff Nurse (Job Training, Description and Assessment)

Training (All (eleven) hospitals provided forms)

The training programme undergone by the staff nurse grade is that undergone by the student nurse (See Appendix 19), and the material presented above relating to the student nurse.

Job Description (Eight hospitals provided forms)

Eight near identical staff nurse job descriptions were obtained (See Appendix 20). The staff nurse job description was almost identical to that of the charge nurse grade (See Appendix 21) and was composed of three major areas:

- A. Professional
- B. Administrative
- C. Personnel

References to patient care were relatively few and lacking in precise detail. They are:

"Reporting conditions of patients to medical staff and, when necessary, to ward sister/charge nurse, and receiving instructions."

and

"Carrying out some nursing procedures and treatments."

and

"Maintaining personal contacts with patients through ward rounds, conversations, etc."

Assessment (Eight hospitals provided forms)

Seven hospitals used the same form for assessing enrolled nurses, staff nurses and charge nurses (See Appendix 18). References to specific areas of care tended to be minimal and non-specific.

Examples are:

"Acceptance of change"

and

"Awareness of the total needs of patients, both clinical and personal."

The eight hospitals used similar assessment forms for the three grades and each form was similar to that used by the other seven hospitals.

Summary of staff nurse training, job description and assessment.

While training given to the nurse preparing to become a staff nurse was very different from that given to the nurse preparing to become an enrolled nurse, their job descriptions and means of assessment were virtually identical. The job description and assessment form for the staff nurse grade was virtually identical to that of the charge nurses grade, the training being identical.

Charge Nurse (Job Training, Description and Assessment)

Training (All (eleven) hospitals provided forms)

The training programme undergone by the charge nurse grade is that undergone by the student nurse (See Appendix 19) and the material presented above relating to the student nurse. Charge nurses are recruited from the staff nurse grade without any further professional training, although attendance at a basic level management course is often required.

Job Description Eight hospitals provided forms

Eight near identical job descriptions were obtained (See Appendix 21) and these were virtually the same as the sample job descriptions for the charge nurse grade presented in the report of the Ministry of Health and the Scottish Home and Health Department (1966). They contained, as did those for staff nurses, limited and rather vague references to patient care.

Assessment Eight hospitals provided forms

Seven hospitals used the same form for the assessment of enrolled nurses, staff nurses and charge nurses (See Appendix 18). The eighth hospital used separate (although near identical) forms for the three grades. Each of the three forms was virtually identical to that used by the other seven hospitals to assess all three trained staff grades.

Summary of the charge nurse training, job description and assessment.

Comments are the same as those which apply to the staff nurse grade (see above).

Summary All six grades.

None of the six grades of ward based psychiatric nurses included in this study had had a training which was clearly reflected in the job description and in the criteria for assessing the nurses' performance. References to physical illness and related nursing care tended to be emphasised relative to non-physical illness and related care. Not only did physical care dominate, but it was expressed in terms which were more specific than were references to non-physical care.

Despite the shorter, less specialised and physical-care orientated type of training used to prepare the enrolled nurse, the job description and means of assessing that grade was virtually identical to the job description and assessment of the charge nurse and staff nurse. The job descriptions for all three grades of trained nurse have been copied directly from that of the charge nurse job description contained in the report of the Ministry of Health and the Scottish Home and Health Department (1966). The report presented a near identical job description for the charge nurse working in a psychiatric hospital, and a charge nurse working in a surgical ward within a district general hospital, the former having the following item added:

"Assists medical staff in observing the legal requirements of the Mental Health Act."

CHAPTER 9

DISCUSSION OF RESULTS

A total of 4,477 Critical Incidents relating to the ward based psychiatric nurse were collected from patients and staff of eleven Scottish psychiatric hospitals. The incidents were classified in a seventy two element classification system. The four major AREAS of the classification system being;

- AREA A "STAFF INITIATED THERAPEUTIC INTERVENTION"
- AREA B "ADMINISTRATIVE ACTIVITY"
- AREA C "PROVIDES, PLANS FOR, OR MONITORS PHYSICAL CARE"
- AREA D "PERSONNEL ACTIVITY"

The work of the ward based psychiatric nurse, as described in classified critical incidents, will be used to achieve four closely related aims viz;

- Aim i) "To obtain an objective basis by which to assess patients' nursing needs" Elements of the classification system will be used to assist with the identification of patients' nursing needs. It is recognized that some elements of the system will have more general applicability, while others will apply only to a small number of patients. An example of the former is "Makes self available to patients", and of the latter "Responds to aggressive/hostile behaviour".
- Aim ii) "To formulate criteria by which to measure the effectiveness of the work of the psychiatric nurse." Having identified patients' specific nursing needs and provided the appropriate nursing care, elements of the classification system will be used to determine the effectiveness of the implemented nursing care. While it is not anticipated that objective criteria for the measurement of nursing care effectiveness will be identified, it is anticipated that the classification system can be used to suggest improvement in the present level of objectivity. For example, nurses presently refer to patients being "much improved" as a result of

nursing care. The ambiguity of this measure of nursing care effectiveness results, in large part, from the absence of specific nursing goals. The classification system, with its specific elements of nursing activity, and patient need, will enable a more specific, and less ambiguous measure of nursing effectiveness to be made. For example, if in relation to a particular patient the nurse requires to "Expose patient to institutional and non-institutional social experiences", the extent to which the intended activity has, or has not been, effectively undertaken will be relatively easy to measure.

Aim iii) "To provide an objective appraisal of the educational needs of the psychiatric nurse." At present, three very different forms of training are provided for the three grades of untrained ward based nursing staff, these being:

Student nurse: Three year formal specialist training
(See Appendix 19)

Pupil nurse: Two year formal generalist training
(See Appendix 15)

Nursing assistant: Up to two weeks, informal training
(See Appendix 12)

The questions which at present are largely unanswered and relate to the training of the psychiatric nurse are: First, do the differences in the roles of ward based nurses of different grades justify the very great differences which exist in their training programmes? Second, what should be the content of the educational programme undergone by ward based psychiatric nurses? The classification system, with its specific elements will, hopefully, throw some light on the education required to prepare nurses to fill their role. Further analysis of the classified critical incidents will facilitate comment on the required differences and similarities in the education of the various ward based nurse grades.

Aim iv) "To provide a basis for an objective assessment of nursing performance." Currently, a number of differing assessment schedules exist for the various nurse grades who provide clinical care. The means of assessing ward based psychiatric nurses contains three important deficits which may be shown by reference to the classified critical incidents. First, the similarity in the role of the varying nurse grades is not reflected in the content of the assessment schedules which are used to assess the clinical performance of nursing staff. Second, the content of assessment schedules tends to be relatively vague, referring to such abilities as "Identifies patients needs". Third, the areas on which nurses are assessed do not reflect the range of activities which, according to the classified critical incidents, are perceived as constituting effective nursing practice.

Aims (i) to (iv) above will be discussed in the light of three major conclusions resulting from analysis of how the critical incidents were distributed between shifts, specialties and staff grades. Psychiatric nursing, and the context in which it takes place is currently divided into a number of sub-units, for example day shift and night shift. If the nursing which takes place in day time is significantly different from that which occurs during night time, the implications for job training and job assessment are clearly considerable. Similarly, if the role of the nurse differs significantly between grades, the implications for job training and nurse assessment require to be taken into account.

In order to maximise the clarity and specificity of this aspect of data analysis, only the Sub-category part of the classification system will be referred to. The relatively high numbers of Sub-categories in the system, compared to AREAS and Categories, facilitate comparisons being made. Also, the relatively specific nature of the Sub-category content will enable more meaningful comment to be made on shift, specialty and staff grade differences and similarities. The decision to use Sub-category material for the purpose of discussing shift, specialty and grade differences was made with recognition of the fact that inter-rater reliability tended

to be weaker at this level than at AREA and Sub-category levels (See Appendix 11 and p72 - 77 for a discussion of inter-rater reliability).

The discussion presented below is based on 4477 classified critical incidents which were used to construct a description of the work of the ward based psychiatric nurse. It is important the reader recognise that it is not being claimed that the 4477 classified incidents represent a totally comprehensive description of the work of the ward based psychiatric nurse. It may be, for example, that respondents chose to omit aspects of their work because they either felt these were unimportant or not a legitimate part of the nurses' role. Clearly the nature of those items which may have been omitted and their potential influence on the data cannot be directly ascertained. What can be said of the data, and the resultant classification scheme, is that the role of the ward based psychiatric nurse is no less than that described by the classified critical incidents. The following discussion, therefore, will assume that while the work of the psychiatric nurse may be greater than that described by the data, it will be no less.

Differences Between Shifts

Of the thirty five Sub-categories which contained large enough numbers of critical incidents to enable a χ^2 test to be applied, six were over-represented on night shift, and seven were over-represented on day shift. The χ^2 detected no significant difference in the distribution of incidents between shifts in the remaining twenty two Sub-categories.

Incidents in the following six Sub-categories were over-represented on night shift:

| AREA | Category | Sub-category | |
|------|----------|--------------|---|
| A | I | 2 | "Provides opportunities or encourages patients to talk about their problems" |
| A | II | 4 | "Individualizes patient care. Adapts the environment, routine or care to suit individual patients' needs" |

| AREA | Category | Sub-category | |
|------|----------|--------------|---|
| A | II | 6 | "Observes or supervises patients" |
| A | IV | 5 | "Responds to patients anxiety, over-activity or over-stimulation" |
| C | II | 6 | "Promotes sleep" |
| D | I | 4 | "Reports on staff changes or shortages to senior staff and/or ensures adequate numbers of nursing staff." |

Although incidents relating to night shift were over-represented in each of the above six Sub-categories, none of these contained incidents which were exclusive only to that shift. The only AREA which is not represented in the above six Sub-categories is AREA B "ADMINISTRATIVE ACTIVITY", indicating that no part of that AREA is shift specific.

Incidents in the following seven Sub-categories were over-represented on day shift:

| AREA | Category | Sub-category | |
|------|----------|--------------|---|
| A | I | 6 | "Recognizes and encourages patients' individuality. Emphasises worth of patient and maximizes level of self-esteem" |
| A | I | 2 | "Encourages or facilitates patient playing an active part in treatment or self care. Encourages independence" |
| A | II | 7 | "Makes therapeutic use of staff-patient or patient-patient groups" |
| A | IV | 6 | "Negatively reinforces pathological behaviour" |

| AREA | Category | Sub-category | |
|------|----------|--------------|---|
| C | II | 2 | "Selects or initiates appropriate physical care" |
| C | II | 3 | "Recognizes personal limitations when delivering care" |
| C | II | 4 | "Is aware of patients treatment, physical needs and care" |

Although incidents relating to day shift were over-represented in each of the above seven Sub-categories, none of these contained incidents which were exclusive only to that shift. The only AREA which is not represented in the above Sub-categories is AREA B "ADMINISTRATIVE ACTIVITY" indicating that no part of that AREA is shift specific.

On the thirteen occasions when a significant difference in the distribution of incidents between shifts was detected, the incidents were not confined to the over-represented shift. The content of the Sub-categories which were shift specific were dispersed throughout a number of AREAS and/or Categories, preventing identification of specific role elements which were peculiar to either shift. The numbers of Sub-categories which were specific to either day or night shift constituted a relatively small part of the overall classification system suggesting that, in general, the role of the ward based psychiatric nurse, while not shift specific, does contain some degree of shift emphasis.

Differences Between Specialties

Of the thirty seven Sub-categories which contained sufficient numbers of critical incidents to enable a X^2 test to be applied, fourteen were found to have a significant difference in the distribution of incidents between specialties.

Incidents in the following nine Sub-categories were over-represented in the acute specialty:

| AREA | Category | Sub-category | |
|------|----------|--------------|---|
| A | I | 2 | "Provides opportunities, or encourages patients to talk about their problems" |

| AREA | Category | Sub-category | |
|------|----------|--------------|---|
| A | I | 3 | "Is warm, understanding and sympathetic towards patients. Delivers care with sensitivity. Demonstrates empathy" |
| A | I | 4 | "Reassure patient. Encourages feeling of confidence, security or optimism" |
| A | I | 10 | "Gives patient explanation of treatment, nursing care or nursing decisions" |
| A | I | 13 | "Maximises staff-patient trust" |
| A | II | 5 | "Introduces patient to ward rules, geography, staff or other patients" |
| A | II | 7 | "Makes therapeutic use of staff-patient or patient-patient groups" |
| A | IV | 1 | "Responds to aggressive behaviour" |
| A | IV | 2 | "Establishes cause of pathological behaviour" |

On the nine occasions when the acute specialty was significantly over-represented, the incidents were not confined to that specialty. Specialty differences, therefore, are in terms of emphasis and relate to a relatively small number of role elements (nine) identified in this classification system. However, all Sub-categories in which the acute specialty was over-represented were contained within AREA A "STAFF INITIATED THERAPEUTIC INTERVENTION", this may indicate that the role emphasis in the acute specialty relates to some aspects of staff initiated therapeutic intervention. The nature of the nine Sub-categories suggest a tendency for the nurse role in the acute specialty to be closer to a psycho-therapeutic role than that of nurses in the other two specialties. It may be that nurses working in this specialty do have a role which is different to that from those working in the geriatric or long stay specialties.

If so, the implications for training, job description and clinical assessment will have to be taken into account. Alternatively, it may be that the difference is only in terms of emphasis, nurses in the acute specialty being more involved in this type of work. If the latter assumption is true then the acute specialty may be regarded as an area where, because of the frequency with which "STAFF INITIATED THERAPEUTIC INTERVENTION" is performed, nursing expertise can be developed and taught to nurses generally.

Incidents in the following four Sub-categories were over-represented in the long stay specialty:

| AREA | Category | Sub-category | |
|------|----------|--------------|---|
| A | I | 7 | "Encourages or provides social stimulation. Exposes patient to institutional or non-institutional social experiences" |
| A | II | 2 | "Encourages or facilitates patient playing an active part in treatment or self care. Encourages independence" |
| A | IV | 1 | "Responds to aggressive behaviour" |
| A | IV | 6 | "Negatively reinforces pathological behaviour" |

On the four occasions when the long stay specialty was over-represented, the incidents were not confined to that specialty. Specialty differences, therefore, are in terms of emphasis and relate to a relatively small number of role elements (four) in this classification system.

As with the acute specialty, all Sub-categories in which the long stay specialty was over-represented were in AREA A "STAFF INITIATED THERAPEUTIC INTERVENTION". This may indicate that the role emphasis in the long stay specialty relates to some aspects of staff initiated therapeutic intervention. The nature of the Sub-categories, particularly A I 7 and A II 2, suggest a rehabilitative type role seeking to re-establish social and independence skills in

the long stay psychiatric patient.

Incidents in the following six Sub-categories were over-represented in the geriatric specialty:

| AREA | Category | Sub-category | |
|------|----------|--------------|---|
| A | I | 7 | "Encourages or provides social stimulation. Exposes patient to institutional or non-institutional social experiences" |
| A | I | 10 | "Gives patient explanation of treatment, nursing care or nursing decisions" |
| A | II | 2 | "Encourages or facilitates patients playing an active part in treatment or self care. Encourages independence" |
| A | II | 4 | "Individualises patient care. Adapts the environment, routine or care to suit individual patients" |
| A | IV | 2 | "Establishes cause of Pathological behaviour" |
| A | IV | 5 | "Respond to patients anxiety, over-activity or over-stimulation" |

On the six occasions when the geriatric specialty was over-represented, the incidents were not confined to that specialty. Specialty differences, therefore, are in terms of emphasis and relate to a relatively small number of role elements (six) in this classification system.

As with the acute and long stay specialties all Sub-categories in which the geriatric specialty were over-represented were in AREA A "STAFF INITIATED THERAPEUTIC INTERVENTION". This may indicate that the role emphasis in the geriatric specialty relates to some aspects of staff initiated therapeutic intervention. The nature of the Sub-categories suggests a rehabilitative type role seeking to establish or maintain social and independence skills and nursing

intervention relating to pathological behaviour.

All specialty differences were detected only within AREA A "STAFF INITIATED THERAPEUTIC INTERVENTION". Although statistically significant, these differences were in terms of emphasis only, and did not suggest a general or dramatic difference in the roles of nurses working the acute, long stay or geriatric specialties.

The absences of significant differences in the distribution of incidents in the remaining three AREAS, B, C, and D were equally relevant to all three specialties. In general terms, it may be concluded that specialty differences within psychiatric nursing are minimal and not sufficiently large to justify differences in job training, job description or job assessment. This finding contrasts with that of Towell (1975) who concluded that the differences in nurse roles were quite radical depending on the specialty setting. Mitchell and Hughes (1980) implied, without any supporting evidence, that nurses caring for the elderly or chronically ill require a shorter training period than did nurses caring for the acutely ill. However, it may be that the difference between the finding of this study, and that of Towell (1975) results from the differences in methods of data collection. For example, it is possible that nurses in this study working in the geriatric specialty omitted providing incidents relating to what they perceived as being "routine" nursing tasks, and that these were not performed by nurses in the acute specialty.

Differences Between Staff Grades

Of the twenty two Sub-categories which contained sufficient numbers of critical incidents to enable a χ^2 test to be applied, three contained a significant difference in the distribution of incidents between grades.

Incidents in the following three Sub-categories were over-represented in relation to one or more of the six staff grades. The over-represented staff grades are marked with a * .

| AREA | Category | Sub-category | |
|------|----------|--------------|--|
| A | I | 2 | "Provides opportunities for, or encourages patients to talk about their problems" C.N., Sf.N. [*] , E.N. [*] , St.N. [*] , P.N., N.A. |
| A | I | 7 | "Encourages or provides social stimulation. Exposes patient to institutional or non- institutional social experiences" C.N., Sf.N., E.N., St.N., P.N. [*] , N.A. [*] |
| C | II | 6 | "Promotes sleep" C.N., Sf.N., E.N. [*] , St.N., P.N., N.A. [*] |

In relation to three of the twenty two Sub-categories to which the χ^2 test was applied, significant differences in the distribution of critical incidents between staff grades was detected. This over-representation applied to one or more of the staff grades, with the exception of the charge nurse, in at least one of the three Sub-categories described above. In relation to one Sub-category, A I 7, the two least qualified nurse grades were reported on significantly more often than were the other four grades.

Despite the significant χ^2 results obtained, all staff grades were reported on in relation to each of the three Sub-categories described above. These differences, relating as they did to only three of the twenty two Sub-categories subjected to the χ^2 , do not suggest a general difference in the role of the six nurse grades working in psychiatric wards. Rather, as with shift and specialty differences, the difference is in terms of emphasis rather than in terms of clear or marked role specialization.

It would seem from the above analysis of data that it is reasonable to talk of a psychiatric nurse role (singular) rather than about a number of significantly differing roles for each of the staff grades. It is being increasingly recognised that the role overlap between nurses of all grades is considerable and that it applies to untrained staff (nursing assistants) and trained staff (registered and enrolled nurses). The Report of the Committee on Nursing (1972) commented

on the similarity of the work done by registered nurses and enrolled nurses. Jeffries (1980) and Hardie and Macmillan (1980) in discussions of role of the enrolled nurse fully recognised the similarity in the work undertaken by that grade and by both registered nurses and nursing assistants.

A similar situation exists with regard to the role of the registered nurse and the nursing assistant, this being clearly expressed by Perry (1978) who wrote;

"In principle nursing auxiliaries (assistants) should not be expected to undertake duties requiring the knowledge and skill of qualified nurses, but it is not easy to be precise about the exact nature of duties requiring professional knowledge and skill" p 50

The difficulties associated with identifying the differences in the role of the least qualified clinical nurse (nursing assistant) and the most qualified (registered nurse) have been given increasing attention in recent years. Swearingen and Thompson (1978), in a discussion of the nursing assistant grade concluded that a predominantly non-professional staff with a minimum of professional supervision provided psychiatric care that was highly satisfactory to patients. Hardie (1978) in a comparison of the work of the registered nurse and the nursing assistant claimed that all tasks in the registered nurse training syllabus, with the exception of injections and certain forms of drainage, were being carried out somewhere in the United Kingdom by nursing assistants. Lambert (1978) recommended that the presently increasing amount of nursing care which is given in Scotland by nursing auxiliaries should be limited in the interests of improving the standards of patient care. Altschul (1978) implied that some aspects of the nursing assistants' contribution to care were items which qualified nurses should be performing, but were not, when she wrote;

"We did agree that the chief virtue of the auxiliary is her humanity, her ability to listen, to have empathy, to have spare time. This is extremely depressing in the implications that it has for nurses" p 202

This study, therefore, has established the existence of only minimal differences between the work of the six ward based grades of nursing staff. This finding confirms much of the recently

expressed opinion about minimal role differences between grades. It confirms the view of Cang (1978) who reflected the widespread feeling that the work of the nursing auxilliary was in some important sense different from that of the qualified nurse, but that it was hard to state exactly what the difference was.

The considerable similarity in the work done by trained staff, nurses in training and nursing assistants can also be considered in relation to professionalism in nursing. Rye (1980) in discussing the development of nursing as a profession suggests that the development is, as yet, embryonic. That writer also refers to the importance of autonomy as a feature of "professionalism". Other writers including Coe (1970), McGilloway (1980) and Scott (1980) suggested that formal qualifications or specific educational or entry requirements were the hallmark of a profession, implying that such qualifications or education would enable the members of the profession to undertake activities which non-members could not. Clearly the findings of this study do not suggest the existence of work functions which were only undertaken by trained staff.

Other writers, for example Bately (1980) and Chapman (1980) have proposed that professionalism has less to do with education and registers of members than with the personal values, attributes and codes of conduct of the profession's members. If their view is accepted then trained nurses, nurses in training and nursing assistants might be regarded as part of the nursing profession provided they have the necessary personal qualities. Indeed, if the comments of Altschul (1978) are generally applicable, the real professional nurses may be the nursing auxilliaries whose chief virtues are ability to listen, to have empathy and to have spare time. Furthermore, the whole question of the need for a specialist training in psychiatric nursing must be examined when, as Vousden (1980) observed, it is possible to work in a psychiatric hospital as a staff nurse with only a Registered General Nurse training and, potentially, no knowledge of psychiatry or of nursing the mentally ill.

The conclusion relating to the considerable similarity of the role of differing staff grades in this study may be criticised on the basis that, although the different nurse grades were performing essentially the same activities, some groups may have been performing

effectively while others were performing ineffectively.

TABLE 18 below presents the differences in the distribution of EFFECTIVE and INEFFECTIVE incidents as they relate to each of the six grades who were reported on. It is recognised that the overall distribution of effective incidents (58.9%) and ineffective incidents (41.1%) is of no intrinsic value, but that the relative differences in distribution between grades gives an indication of the perceived effectiveness/ineffectiveness of the work of nurses in that grade. A total of 5384 staff were reported on (some incidents related to all staff grades). The distribution of incidents used to calculate EXPECTED FREQUENCIES were derived from the following over-all distribution.

| | |
|---------------------|-----------------------|
| EFFECTIVE INCIDENTS | INEFFECTIVE INCIDENTS |
| 3172 (58.9%) | 2212 (41.1%) |

TABLE 18

| Distribution of EFFECTIVE-INEFFECTIVE incidents between grades reported on (N = 5384) | | |
|--|-----------|-------------|
| GRADE | EFF. INC. | INEFF. INC. |
| Charge nurse | 830 | 551 |
| Staff nurse | 436 | 294 |
| Enrolled nurse | 621 | 449 |
| Student nurse | 361 | 251 |
| Pupil nurse | 244 | 167 |
| Nursing assistant | 680 | 500 |
| Total | 3172 | 2212 |
| $\chi^2 = 2.59$ N.S. at 0.05 level 5 d.f. | | |

No significant difference was detected in the distribution of incidents between grades in relation to their ability to function effectively or ineffectively. Similarly, differences which exist as a function of shift, specialty or of nurse grade are minimal and are considerably fewer than the similarities. Future discussion

will, therefore, refer to a single role for the psychiatric nurse, when considering the four aims outlined in Chapter 4.

Aims (i) and (ii)

"To obtain an objective basis by which to assess patients' nursing needs and to formulate criteria by which to measure the effectiveness of the work of the psychiatric nurse."

Unless a framework of patients' nursing needs is available to those who nurse patients, and those who educate nurses, decisions about nurses' education and about the required nursing care becomes relatively difficult. Although the assessment framework will not describe the care required to minimise, or solve, a specific problem, it can help to identify the needs requiring nursing intervention.

Traditionally, nurses have relied on vague and relatively non-specific descriptions of patients' nursing needs. For example, a patient may be described as being in need of "rehabilitation", or "general nursing care", or of "emotional support". Mager (1972) labelled these non-specific and vague descriptive titles "fuzzies", specific descriptions he entitled "non-fuzzies". He cites the example of the nurses who suggested that "showing concern for patient welfare" as being an important specific skill required by nurses; this he labelled a "fuzzy". However, after considerable discussion the nurses abandoned their "fuzzy" in favour of preventing "unnecessary exposure to embarrassment" as being a hallmark of a good nurse. This requirement was then expressed in the following "non-fuzzy" terms;

The nurse does not:

- (a) leave the patient exposed physically
- (b) treat patients in a socially derogatory manner
- (c) insult patient's values
- (d) insult patient's medical knowledge
- (e) bawl out staff in patients' presence
- (f) ask more intimate questions than needed to do the job

p 91 - 92

From (a) to (f) above, the reader can make inferences regarding patients' nursing needs, for example that patients should not be physically exposed. Not only is the patients' nursing need stated in specific terms, the skill becomes easier to teach and assess because of its specificity.

It is not intended that the classification system constructed in this study be used as a framework for assessing all needs of all psychiatric patients in all circumstances. Indeed, it may be that some areas of nursing activity, and of patients' nursing needs, are not included in the classified critical incidents. However, those items which are included are known to form an important part of the role of the ward based psychiatric nurse.

Critical incidents were first classified in an AREA, which tended to be considerably less specific than the next level of classification, the Category, maximum specificity was achieved at Sub-category level. Despite the non specific nature of AREA and Category levels, these are necessary to place individual elements of the system in context and in relationship to the classification as a whole.

Each item in the system serves two purposes; (i) to identify patient need and (ii) to form the basis of the measurement of effectiveness of the work of the psychiatric nurse (Aims i and ii).

The following framework (See FIGURE 3), therefore, serves two purposes; each item is an expression of patients' potential needs, it also forms the basis on which the steps taken to satisfy that need (nursing care) can be evaluated. The framework is derived from, and reflects, the classified critical incidents;

FIGURE 3

- (i) Framework of patients' potential nursing needs
- (ii) Framework for evaluation of nursing care

In relation to (i) above each item in the framework should be prefixed with "All patients have a potential need for"

In relation to (ii) above each item in the framework is the potential subject of the evaluation of nursing care.

| <u>AREA</u> | <u>Category</u> | |
|-------------|-----------------|--|
| A | | "NURSING STAFF TO INITIATE THERAPEUTIC INTERVENTIONS" |
| A | I | "Nurses To Function As Therapeutic Tools" |
| A | I | <u>Sub-categories 1 - 16</u> |
| | | 1. Availability of nursing staff. |
| | | 2. Opportunities to discuss problems with nursing staff. |
| | | 3. Warmth, understanding and sympathy, to be cared for with empathy. |
| | | 4. Reassurance, confidence and to be made to feel secure and optimistic. |
| | | 5. Planned, specific one-to-one nurse-patient relationships. |
| | | 6. Recognition of personal individuality and worth. Self-esteem to be maximised. |
| | | 7. Opportunities for institutional and non-institutional social stimulation and experiences. |
| | | 8. Communication difficulties to be minimised. |
| | | 9. Nurses to recognise their personal limitations. |
| | | 10. Explanations to be given relating to treatment, nursing care or nursing decisions. |
| | | 11. Identification of intellectual, spiritual, emotional or social needs or limitations. |
| | | 12. Encouragement to accept treatment or nursing care. |

| <u>AREA</u> | <u>Category</u> |
|-------------|-----------------|
|-------------|-----------------|

13. Staff-patient trust to be maximised.
14. Most appropriate nursing care to be chosen.
15. Nurses to present themselves as role models.
16. Consistency in delivery of nursing care.

Patients were also reported as having the need for;

| <u>AREA</u> | <u>Category</u> |
|-------------|-----------------|
|-------------|-----------------|

| | | |
|---|----|---|
| A | II | "Nurses To Make Therapeutic Use Of The Environment" |
|---|----|---|

| | | |
|---|----|-----------------------------|
| A | II | <u>Sub-categories 1 - 7</u> |
|---|----|-----------------------------|

1. Encouragement in achieving patient-patient understanding or relationships.
2. Increasing personal independence and participation in self care.
3. Optimum level of privacy.
4. Individualised care, and to have the environment or routine adapted to meet personal requirements.
5. Introduction to ward rules, geography, staff or other patients.
6. Observation or supervision.
7. Opportunities to make therapeutic use of staff-patient or patient-patient groups.

Patients were also reported as having the need for;

| <u>AREA</u> | <u>Category</u> |
|-------------|-----------------|
|-------------|-----------------|

| | | |
|---|-----|---|
| A | III | "Nurses To Effectively Deal With Or Communicate With Relatives" |
|---|-----|---|

| | | |
|---|-----|-----------------------------|
| A | III | <u>Sub-categories 1 - 3</u> |
|---|-----|-----------------------------|

1. Relatives to be given correct explanation of, or information relating to patients' illness, treatment or nursing care.
2. Relatives to be comforted.
3. Relatives to be encouraged to play an active part in treatment.

Patients were also reported as having the need for;

| <u>AREA</u> | <u>Category</u> |
|-------------|-----------------|
|-------------|-----------------|

| | | |
|---|----|---|
| A | IV | "Their Pathological Behaviour Effectively Responded To" |
|---|----|---|

| | | |
|---|----|-----------------------------|
| A | IV | <u>Sub-categories 1 - 7</u> |
|---|----|-----------------------------|

1. Aggressive behaviour effectively responded to.
2. Cause of pathological behaviour established.
3. Orientation to be given, to be focussed on reality.
4. Limits to be set on behaviour.
5. Anxiety, over-activity or over stimulation to be effectively responded to.
6. Pathological behaviour to be negatively re-inforced.
7. Pathological behaviour to be anticipated and minimised or prevented.

Patients were also reported as having the need for;

| <u>AREA</u> | <u>Category</u> |
|-------------|-----------------|
|-------------|-----------------|

| | | |
|---|---|--|
| A | V | "Nurses To Function As Part Of A Therapeutic Team" |
|---|---|--|

| | | |
|---|---|-----------------------------|
| A | V | <u>Sub-categories 1 - 2</u> |
|---|---|-----------------------------|

1. Nurses to comply with treatment approach or programme agreed by the team.
2. Nurses to keep themselves and others aware of clinical data relating to patients, and to obtain, when necessary, non-nursing care for patients.

Patients were also reported as having the need for;

| <u>AREA</u> | <u>Category</u> | |
|-------------|-----------------|--|
| B | | "ADMINISTRATIVE ACTIVITY" |
| B | I | "Nurses To Have Available Non-Clinical Patient Data" |
| B | I | <u>Sub-categories 1 - 2</u> 1. Nurses to be aware of the identity of patients. 2. Nurses to be familiar, when necessary, with the location of patients. |
| B | II | "Adequate Stocks Of Equipment And Supplies." |
| B | III | "Their Property To Be Protected And Kept Secure" |
| B | III | <u>Sub-categories 1 - 3</u> 1. Arrangements to be made for the security of their property. To have a current list of their property kept and to be informed, when necessary, of the location of their property. 2. Respect to be shown for their property. 3. Arrangements to be made for laundering or repair of clothing. |

Patients were also reported as having the need for;

| <u>AREA</u> | <u>Category</u> | |
|-------------|-----------------|--|
| C | | "THE PROVISION OF PHYSICAL CARE" |
| C | I | "Medications To Be Administered" |
| C | I | <u>Sub-categories 1 - 3</u> 1. Medications to be administered carefully, accurately and as prescribed. 2. Observation and assistance to ensure that medications are taken. 3. Observation and monitoring of side effects of medication. |

Patients were also reported as having the need for;

| <u>AREA</u> | <u>Category</u> | |
|-------------|-----------------|--|
| C | II | "Physical Care" |
| C | II | <u>Sub-categories 1 - 7</u> |
| | | 1. Physical health to be monitored. |
| | | 2. Appropriate physical care to be selected or initiated. |
| | | 3. Nurses to recognise personal limitations when delivering physical care. |
| | | 4. Nurses to be aware of patients' treatments, physical needs and care. |
| | | 5. Nurses to plan physical care in advance of it being delivered. |
| | | 6. Sleep to be promoted. |
| | | 7. Protection from potentially hostile environments, potentially harmful items to be removed from the environment. |

Patients were also reported as having the need for;

| <u>AREA</u> | <u>Category</u> | |
|-------------|-----------------|--|
| D | | "PERSONNEL CONTRIBUTION TO BE MAXIMISED" |
| D | I | "Staff Contribution To Be Maximised" |
| D | I | <u>Sub-categories 1 - 4</u> |
| | | 1. Staff suggestions to be encouraged and accepted by other nurses, and for proposed changes to be discussed with nurses involved. |
| | | 2. Workload or work routine to be arranged in order to maximise staff effectiveness and/or patient care. |
| | | 3. Staff to make optimum use of personal skills and to encourage others to do so. |
| | | 4. Staff shortages to be reported. |
| D | II | "Nurses To Be Taught, Counselling Or Given Orientation " |

The above patient potential needs were identified from the critical incidents. It is suggested that each patient can be assessed in relation to the above framework of nursing needs, and the appropriate nursing care initiated (Aim i). The nature of the nursing care required to satisfy each identified need is outwith the scope of this study in terms of detailed examination. However, reference to the ABSTRACTS which relate to each element of the assessment framework (See Chapter 7) will provide one or two specific examples of the way in which nurse respondents described how the need should, or should not, be satisfied.

It is suggested that the above assessment framework, and resulting nursing care, can be more objectively measured by virtue of its inherent specificity (Aim ii). For example, if the nurse identifies a patient as requiring "exposure to social stimulation", the outcome of the resultant nursing care can be more objectively assessed than if the nursing prescription had been "prevent social deterioration". The extent to which the outcome of the nursing care has been effective, or otherwise, can now be measured by reference to "Expected Outcome". For example, if a patient was being exposed to social stimulation in order to reverse an existing inability to participate in an everyday social event, shopping for example, the "Expected Outcome" of the nursing care might be:

"Visits the hospital shop with a nurse and buys one item"

or

"Visits the hospital shop alone and buys one item"

or

"Visits a shop in town and buys one item"

The assessment framework is a starting point for identifying patients' nursing needs, for example "exposure to social stimulation". These are made more specific when considered in relation to the needs of the individual patient, for example, "learn how to shop unaccompanied". Once the need is expressed in these specific terms, the task of evaluating nursing care becomes easier and more objective (Aim ii).

Aim (iii)

"To provide an objective appraisal of the educational needs of the psychiatric nurse."

At present, all nurses are exposed to a variable mixture of theoretical and practical nursing educational input. The extent to which that educational input is designed to reflect patients' nursing needs is contentious, particularly when one considers the lack of information relating to the nursing needs of the hospitalised mentally ill, and to the role of the psychiatric nurse.

Items in the framework constructed from the classification of critical incidents will be used to prepare educational objectives for the psychiatric nurse. For example in relation to the need for the nurse to "Make self available to patients", educational input must result in the nurse being able to;

- 1) describe the importance of the availability of the nurse to the patient;
- 2) describe how the nurse is perceived as being "available";
- 3) describe how the nurse can increase the patients' perception of her availability;

As with the framework of patients' nursing needs, the framework of educational objectives is least specific at AREA level, more specific at Category level, and most specific at Sub-category level. However, despite the relative lack of specificity at AREA and Category levels, their inclusion will help to put educational objectives derived from Sub-category incidents into context and clarify their relationship to each other. The words which are used to prefix the actual behavioural objectives, for example the word "Describe" in 1, 2 and 3 above are chosen deliberately because they make the objectives testable. Words like "Understand" have been avoided because of the difficulty in testing nurses' "Understanding" other than by asking for a description.

Accompanying the items in the framework of educational objectives below will be the outcome of the X^2 test designed to measure the difference in distribution between EFFECTIVE and INEFFECTIVE incidents. The extent to which the X^2 detected an over-representation of EFFECTIVE or INEFFECTIVE incidents may well have implications for

the specific elements of the educational process. The writer is aware of the limitation in the conclusions which can be drawn from the χ^2 relating to EFFECTIVE-INEFFECTIVE distribution, but the following two possibilities both have educational implications. Firstly, that those activities which are over-represented in terms of EFFECTIVE incidents are performed relatively well by nursing staff, and relatively poorly where there is an INEFFECTIVE emphasis. Thus, nurse educators, and practitioners may examine their relatively EFFECTIVE activities in an effort to establish the educational input or practical experiences which result in relative effectiveness. Conversely, the relatively INEFFECTIVE activities may require additional or different educational or practical experience inputs to improve nursing performance. A second possible cause of the EFFECTIVE-INEFFECTIVE differences between activities, is that some activities are only noticed when they are done either EFFECTIVELY or INEFFECTIVELY. This possibility has serious consequences for the assessment of nurses practical skills in that much EFFECTIVE or INEFFECTIVE may never be commented on because it is only noticed when it is either effective or ineffective. For example the fact that EFFECTIVE incidents are represented in relation to AREA A, Category I "Uses Self As A Therapeutic Tool" may be indicative of one of two things. Firstly, that nurses perform the activity relatively well, or secondly, that performing it badly is relatively difficult to notice.

The χ^2 test was performed on a total of 40 of the Sub-category activities listed below which form a possible framework of educational objectives. The result of the χ^2 is given after the title of each part of the framework thus;

- (χ^2 N.P.) χ^2 Not Performed
- (χ^2 N.S.) No significant difference in distribution
- (χ^2 E.) EFFECTIVE incidents over-represented
- (χ^2 I.) INEFFECTIVE incidents over-represented

The full result of each χ^2 test, including observed and expected frequencies and the actual χ^2 result, can be found in Chapter 7.

Aim (iv)

"To provide a basis for an objective assessment of nursing performance" will be combined with aim (iii) "To provide an objective appraisal of the educational needs of the psychiatric nurse" since the measurement of the result of educational input can be closely related to the assessment of practical skills resulting from the educational input. Furthermore, the potentially close relationship between nursing theory and practice allows for a common means of assessment to be applied. Bearing in mind the apprenticeship nature of nursing staff education, theory being taught in the classroom, practical experience being gained on the ward, it seems reasonable to have one framework for assessing nursing staff performance from a theoretical and practical viewpoint.

Similarly, the need to devise a different means of appraisal for trained nurses from that of nurses in training is redundant since they contain potentially the same elements. The student nurse on the verge of Registration and the newly appointed staff nurse may be doing virtually the same work. The earlier analysis of critical incidents, and the resultant detection of little significant differences in the role of the nurses, irrespective of grade, suggests the need for a single set of educational objectives. However, a distinction will be made with what the nurse should be able to do as a result of (a) educational input in the classroom and (b) educational experience in the form of ward-based or other clinical practical experience.

In relation to each of the nursing activities listed below, the nurse should be exposed to a classroom based and practical education which will enable her to;

- (a) describe the nature and purpose of the activity;
- (b) describe means of performing the activity;
- (c) describe means of evaluating the result of the activity;
- (d) identify situations requiring the nursing activity;
- (e) perform the nursing activity;
- (f) evaluate the outcome of the activity.

The nurse should develop skills (a) to (f) above in relation to each of the following in FIGURE 4.

FIGURE 4

- (i) Educational needs of ward based psychiatric nurses (all grades)
- (ii) Schedule for the assessment of ward based psychiatric nurses (all grades)

| <u>AREA</u> | <u>Category</u> | |
|-------------|-----------------|--|
| A | | "INITIATING THERAPEUTIC INTERVENTIONS" (X^2 N.S.) |
| A | I | "Uses Self As A Therapeutic Tool" (X^2 E.) |
| A | I | <u>Sub-categories 1 - 16</u> |
| | | 1. Making self available to patients. (X^2 N.P.) |
| | | 2. Providing opportunities for, or encouraging patients to talk about their problems. (X^2 E.) |
| | | 3. Being warm, understanding and sympathetic towards patients. Delivering care with sensitivity, demonstrating empathy. (X^2 I.) |
| | | 4. Reassuring patients. Encouraging feelings of confidence, security or optimism. (X^2 E.) |
| | | 5. Planning or encouraging specific one-to-one nurse patient relationships. (X^2 E.) |
| | | 6. Recognising and/or encouraging patients' individuality: Emphasising worth of patient and maximising level of self esteem. (X^2 N.S.) |
| | | 7. Encouraging or providing social stimulation. (X^2 E.) |
| | | 8. Minimising patients' communication difficulties. (X^2 N.P.) |
| | | 9. Recognising personal limitations when using self as a therapeutic tool. (X^2 N.P.) |
| | | 10. Giving patients explanation of treatment, nursing care or nursing decisions. (X^2 I.) |
| | | 11. Identifying patients' intellectual, spiritual, emotional or social needs or limitations. (X^2 I.) |
| | | 12. Encouraging patients to accept treatment or nursing care. (X^2 N.S.) |
| | | 13. Maximising staff-patient trust. (X^2 I.) |

| <u>AREA</u> | <u>Category</u> |
|-------------|-----------------|
|-------------|-----------------|

14. Choosing appropriate nursing care. (X^2 I.)
15. Presenting self as a role model to patients.
(X^2 N.P.)
16. Being consistent in delivery of care. (X^2 I.)

| | | |
|---|----|---|
| A | II | "Making Therapeutic Use Of The Environment" (X^2 I.) |
|---|----|---|

| | | |
|---|----|-----------------------------|
| A | II | <u>Sub-categories 1 - 7</u> |
|---|----|-----------------------------|

1. Encouraging patient-patient understanding and relationships. (X^2 E.)
2. Encouraging or facilitating patients playing an active part in treatment or self care. Encouraging independence. (X^2 E.)
3. Maximising patients' privacy. (X^2 I.)
4. Individualising patient care. Adapting the environment, routine or care to suit individual patients' needs. (X^2 I.)
5. Introducing patients to ward rules, geography, staff or other patients. (X^2 E.)
6. Observing or supervising patients. (X^2 I.)
7. Making therapeutic use of staff-patient, or patient-patient groups. (X^2 E.)

| | | |
|---|-----|---|
| A | III | "Dealing Or Communicating With Relatives" (X^2 E.) |
|---|-----|---|

| | | |
|---|-----|-----------------------------|
| A | III | <u>Sub-categories 1 - 3</u> |
|---|-----|-----------------------------|

1. Giving relatives correct explanation of, or information relating to, patients treatment, illness or nursing care. (X^2 N.S.)
2. Comforting relatives. (X^2 N.P.)
3. Encouraging or enabling relatives to play an active part in nursing care. (X^2 N.S.)

| | | |
|---|----|---|
| A | IV | "Responding To Patients Pathological Behaviour" (X^2 N.S.) |
|---|----|---|

| | | |
|---|----|-----------------------------|
| A | IV | <u>Sub-categories 1 - 7</u> |
|---|----|-----------------------------|

1. Responding to aggressive behaviour. (X^2 I.)
2. Establishing cause of pathological behaviour.
(X^2 I.)

| <u>AREA</u> | <u>Category</u> |
|-------------|-----------------|
|-------------|-----------------|

3. Focussing patient on reality. Giving patient orientation. (X^2 N.S.)
4. Setting limits on patients' behaviour. (X^2 N.P.)
5. Responding to patients' anxiety, over-activity or over-stimulation. (X^2 N.S.)
6. Negatively reinforcing pathological behaviour. (X^2 N.S.)
7. Anticipating and minimising, or preventing, pathological behaviour. (X^2 N.P.)

| | | |
|---|---|---|
| A | V | "Functioning As Part Of A Therapeutic Team" (X^2 I.) |
|---|---|---|

| | | |
|---|---|-----------------------------|
| A | V | <u>Sub-categories 1 - 2</u> |
|---|---|-----------------------------|

1. Complying with treatment programme or approach agreed by the team. (X^2 I.)
2. Keeping self and others aware of clinical data relating to patients. Obtains or encourages when necessary, non-nursing care for patients. (X^2 E.)

| | | |
|---|--|---------------------------------------|
| B | | "ADMINISTRATIVE ACTIVITY" (X^2 I.) |
|---|--|---------------------------------------|

| | | |
|---|---|--|
| B | I | "Ensuring Availability Of Non Clinical Patient Data" (X^2 N.P.) |
|---|---|--|

| | | |
|---|---|-----------------------------|
| B | I | <u>Sub-categories 1 - 2</u> |
|---|---|-----------------------------|

1. Being aware of identity of patients. (X^2 N.P.)
2. Being familiar, when necessary, with the location of patients. (X^2 N.P.)

| | | |
|---|----|---|
| B | II | "Ensuring That Adequate Stocks Of Equipment And Supplies Are Available" (X^2 N.S.) |
|---|----|---|

| | | |
|---|-----|--|
| B | III | "Protecting And Securing Patients' Property" (X^2 N.S.) |
|---|-----|--|

| | | |
|---|-----|-----------------------------|
| B | III | <u>Sub-categories 1 - 3</u> |
|---|-----|-----------------------------|

1. Arranging for, or offers security for, patients' property. Maintains current list of property and informs patients, when necessary, of its location. (X^2 N.S.)

| <u>AREA</u> | <u>Category</u> |
|-------------|-----------------|
|-------------|-----------------|

2. Showing respect and concern for patients' property. (X^2 N.P.)
3. Arranging for laundering or repair of clothing. (X^2 N.P.)

| | | |
|---|--|--|
| C | | "PROVIDING, PLANNING FOR, OR MONITORING PHYSICAL CARE" (X^2 E.) |
|---|--|--|

| | | |
|---|---|--|
| C | I | "Administering Medication" (X^2 N.S.) |
|---|---|--|

| | | |
|---|---|-----------------------------|
| C | I | <u>Sub-categories 1 - 3</u> |
|---|---|-----------------------------|

1. Administering medications carefully, accurately and as prescribed. (X^2 N.S.)
2. Ensuring by observation or assistance that medications are taken. (X^2 N.S.)
3. Observes and monitors the side effects of medications. (X^2 N.P.)

| | | |
|---|----|-------------------------------------|
| C | II | "Gives Physical Care" (X^2 N.S.) |
|---|----|-------------------------------------|

| | | |
|---|----|-----------------------------|
| C | II | <u>Sub-categories 1 - 7</u> |
|---|----|-----------------------------|

1. Monitoring physical health of patients. (X^2 N.S.)
2. Selecting and/or initiating appropriate physical care. (X^2 N.S.)
3. Recognising personal limitations when delivering physical care. (X^2 I.)
4. Being aware of patients' physical needs and care. (X^2 I.)
5. Planning physical care or treatment in advance of its being delivered. (X^2 N.P.)
6. Promoting sleep. (X^2 E.)
7. Protecting patients from a potentially hostile environment. Removing potentially harmful items from the environment. (X^2 I.)

| <u>AREA</u> | <u>Category</u> | |
|-------------|-----------------|---|
| D | | "PERSONNEL FUNCTION" (X ² I.) |
| D | I | "Maximising Staff Contribution" (X ² I.) |
| D | I | <u>Sub-categories 1 - 4</u> |
| | | 1. Encouraging, accepting and using staff suggestions. Discussing proposed changes with staff. (X ² N.P.) |
| | | 2. Arranging workload or work routine to maximise staff effectiveness and/or patient care. (X ² E.) |
| | | 3. Making optimum use of personal skills, and encouraging others to do so. (X ² I.) |
| | | 4. Reporting on staff changes or shortages to senior staff and/or ensuring adequate numbers of nursing staff. (X ² N.S.) |
| D | II | "Teaching, Counselling Or Giving Orientation To Staff" (X ² E.) |

This framework describes the educational requirements of ward based psychiatric nursing staff and a framework for assessing the knowledge and practical skills of nurses receiving that education. The following example is offered as a reminder of how the educational objectives described on p 211 - 214 might be applied to, for example, the item immediately above;

"Teaching, Counselling Or Giving Orientation To Staff"

Following exposure to a classroom based educational input relating to the above item the nurse should be able to;

- (a) describe the nature and purpose of the activity;
- (b) describe the means of performing the activity;
- (c) describe means of evaluating the results of the activity.

Following exposure to practical educational experience of the above item the nurse should be able to;

- (d) identify situations requiring the nursing activity;
- (e) perform the nursing activity;
- (f) evaluate the outcome of the activity.

The assessment could be used to evaluate the outcome of formal educational input, for example of nurse training, and as an on-going assessment of nurses not in training. The content of the educational input required to achieve the stated educational objectives can be deduced from the educational objectives themselves. For example, in relation to the above example, the nurse must be taught, and receive supervised practice of "Teaching, Counselling And Giving Orientation To Staff". This would apply to each item in the framework.

Training to meet the above educational objectives

The current means of, and time devoted to, training psychiatric nurses was presented in detail in Chapter 8. The combined formal classroom/practical training ranged from a single week in classroom, with or without formal practical education, for Nursing assistants, to a three year training (including 816 hours in classroom) for student nurses. Between the two extremes came enrolled nurses with a two year training which included six week in classroom.

The current emphasis on physical aspects of nursing care has been criticised by a number of writers during the past three decades, and such criticism continues. However, it is not difficult to see how training continues to focus on physical care, the need for which is overt and tangible, as psychiatric nurses continue to struggle with a definition and description of their role and "special" contribution to the care of the hospitalised mentally ill. It may be argued that the undue emphasis on physical aspects of care is reversed when the learner leaves the classroom and continues her education in clinical settings where the charge nurse and the clinical teacher* have major responsibilities for ward based teaching. However, the quantity, quality and relevance of ward based nurse teaching has also been criticised in recent years. For example Thomas and Pinel (1970) and McBrien (1968) commented

Footnote Two groups of nurse teachers are employed in the U.K.; nurse tutors who, in most instances, teach in Colleges of Nursing. The other group, Clinical Teachers, teach almost exclusively in clinical areas, for example, wards.

on the inadequacy of ward based teaching. The latter wrote;

"..... any form of clinical teaching in most psychiatric hospitals is incidental and in some cases non-existent." p 32

The present content of nurse training programmes appear to emphasise what Brown and Fowler (1971) refer to as "High-Visibility Nursing Functions In The Care Of Psychiatric Patients". Those writers define high visibility functions as those in which the nurse uses objects and tools with a degree of manual skill, making a bed or giving an injection for example. The intended purpose of the high visibility function is generally meaningful and discernible to the onlooker, their performance becomes an obvious indicator that the nurse is "busy". High visibility functions can be easily identified and controlled by power figures such as nursing administrators who, according to Brown and Fowler (1971) seem to praise the nurse for tasks that are easily observed, such as maintaining neat bedside units, but may criticise the nurse for talking with a patient unless it is for a special purpose. They go on to hypothesise that high-status personnel may reinforce the performance of high visibility functions.

Low visibility functions are described by Brown and Fowler (1971) as being those which are not easily seen, they include observation of patients, nurse-patient communication skills and the analysis of nurse-patient interaction. In summarising features of low-visibility nursing these writers include the following;

- (i) It is not easily seen by others.
- (ii) It does not utilise objects or manual skills.
- (iii) It is related to psychological aspects of the patient's functioning.
- (iv) It includes verbal and non-verbal elements.
- (v) It does not tend to become routinised.
- (vi) It is difficult to teach to others.
- (vii) It is less controlled by high status (supervisory and administrative) personnel.
- (viii) It is probably less highly rewarded by high status personnel.

High visibility functions, in general, are the opposite of the criteria mentioned above.

An aspect of the high-visibility, low-visibility discussion not referred to by Brown and Fowler (1971) relates to when low-visibility functions receive the attention of high status personnel. Low-visibility functions tend not to come to the attention of, and are not rewarded by, high status personnel, when they are performed satisfactorily. Only when they are not done, or badly done, will their results cause problems which draw them to the attention of those in supervisory or administrative positions. For example, when a nurse demonstrates warmth, empathy and understanding when in contact with a patient, it will more than likely go unnoticed and unrewarded. When this low-visibility function is not performed, or performed badly, the results may cause a patient, relative or other staff member to "complain". Thus, positive reinforcement of the activity is absent and negative reinforcement of a poor performance is present. The result may well be that the activity is not viewed as being a requirement of good nursing care, but rather that its absence is indicative of poor nursing care.

A number of low-visibility functions were reported in this study with the emphasis on INEFFECTIVE incidents. Examples maximising nurse-patient trust, demonstrating empathy, identifying patients' emotional limitations, being consistent in the delivery of care, maximising patients' privacy, observing patients, and establishing the cause of pathological behaviour.

The low value attached to low-visibility nursing functions, arguably the very functions which should attract high value in psychiatric nursing, results from a number of factors including the following. First, the emphasis on high-visibility functions in all three types of nurse training programmes, those given to the student and pupil nurse, and to the nursing assistant. These are relatively easy to teach, particularly in the classroom situation which is used to teach almost all nursing theory. Second, high-visibility functions are relatively easy to describe, learn and assess. Third, the role of high status personnel, including medical and non-clinical administrative nursing staff, limits the choice which ward based clinical nursing staff have in relation to the high/low-visibility emphasis which they place on care. These groups not

only reward high-visibility care, but are in a position to "insist" on its performance if they feel that it has not come up to their standard. For example, a doctor may prescribe "bed rest" for a patient although the nurse may feel that mobility and encouraging independence are more therapeutic. Fourth, the absence of some high-visibility functions may result in life-threatening situations which must be rectified immediately, the need for adequate fluids is an example. Finally, how nurses perceive their role will determine the emphasis which they place on high/low-visibility aspects of their role. If the role is perceived as relating to the medical/somatic model of care, high-visibility functions will predominate. If the role is perceived as relating to the psycho-therapeutic, socio-therapeutic, or behavioural models, low-visibility functions will predominate.

The inadequacy of ward based clinical teaching, is not, many would argue, being supplemented by the teaching which is being carried out by trained staff, including charge nurses and staff nurses, working on the ward with the learners. That many charge nurses have difficulty in teaching was implied by the Royal College of Nursing Association of Nursing Practice and The Royal College of Nursing Association of Nursing Education (1980) when they reported that the Royal College of Nursing Representative Body discuss the need for charge nurses to receive training in teaching methods and to have undergone supervised teaching practice.

Cormack (1975) reported that, among his sample of charge nurses, 2% of total time was spent on teaching activity. He also reported that, during the observation period totalling 168 hours, nurses in training were never sent off the ward to participate in formal teaching activities, nor were they taught on the ward by clinical teachers. The general poor quality of ward based nurse teaching and the relative lack of clinical involvement of teaching staff continues to be the subject of comment for example by Smith (1978). Cowell (1975) in a comment relating to nurse training in Australia likened nurse education to a primitive initiation ceremony, a comparison which, many would argue, applies to this country also.

However, the problems associated with teaching the subject of psychiatric nursing may, in fact, be less of a problem of knowing

how to teach than of knowing what to teach. Two observations may help to support this view. First, trained psychiatric nurses have relatively little difficulty in teaching learners how to undertake physical nursing activity, giving an injection for example. Second, a large number of other groups, for example doctors of medicine and chemists, teach medical and chemistry students without themselves having undergone formal training in teaching methods or supervised teaching practice. It is not being suggested that such a training will not improve the ability of doctors, chemists or nurses to teach others their skills. Rather, it is being suggested that nurses may, unwittingly, be using the lack of formal training in teaching methods as an excuse for not being able to identify the unique elements of their professional activity. Furthermore, while nurses are looking for the solution in improving their teaching skills, they may continue to have difficulty in defining and describing their role.

It seems probable that, in nursing, the most frequently used solution to inadequate or inappropriate clinical performance has been to increase the educational input given to the nurse groups involved. Mager and Pipe (1970) were critical of that approach suggesting that prior to implementing a solution such as more training the basic problem required better identification. They argued that the question "What ought we to be training people for?" must be answered before deciding what training should be given. Therefore, identification of the nursing needs of the mentally ill is a crucial prerequisite to describing the educational needs of nurses caring for them. This study has attempted to answer that question by asking the questions "What do nurses do that can be regarded as effective nursing?" and "What do nurses do that can be regarded as ineffective nursing?" Having identified the skills required by those nursing the hospitalised mentally ill, there remained the question "Which nurses presently caring for the mentally ill require these skills?" Analysis of the differences in the distribution of critical incidents between the six ward based grades reported on suggested that the differences between the role of nurses of varying grades was minimal.

A reader, unfamiliar with the historical development of the current psychiatric nursing staffing structure, may be forgiven for

asking why so many differing staff grades exist and fill the same nursing role? While the historical development has been long, tortuous, sometimes confusing and often without a clear rationale, the following brief comment on the result of that development may clarify the contemporary position. Reference to the training systems, job descriptions and assessment schedules of the six ward based grades of nurses raised a number of questions which can be illustrated by a brief examination of the role of the nursing assistant who is "trained" to assist other staff in the nursing care of patients and to perform mainly physical nursing care. This role makes a number of assumptions which would not stand up to detailed scrutiny.

First, that nursing assistants will always have another nurse (a non-nursing assistant) to "assist". This is known not to be so both during day time shifts when nursing assistants often work independently or with another nursing assistant, or during the night shift when the nursing assistant may be caring for a group of patients on her own. The following abstracted critical incidents demonstrate how a nursing assistant may be functioning relatively independently of other (non-nursing assistant) staff members.

ABSTRACT (Eff. C.N. reporting on N.A. Ger.)

"A nursing assistant was putting a patient to bed when she observed that the patient's walk was peculiar. On investigation she detected a right side weakness which was later found to have been caused by a cerebro-vascular accident. This was effective because the nurse reported the abnormality, which no one else had noticed, this enabled it to be dealt with promptly."

The abstract illustrates two points which do not appear to be fully taken account of in relation to the education, job description and assessment of the nursing assistant. It would seem that the nursing assistant was working on her own in the above instance and, as a result of assessment of the patient's physical status, observed and reported an abnormality caused by a serious physical disorder.

A second major assumption which is made about the role of the nursing assistant is that it is confined to the physical care of

patients; that this is not so is illustrated by the following abstract;

ABSTRACT (Eff. N.A. reporting on self. Ger.)

"A patient was in a state of depression. I took some time off my other duties to sit and talk with her. This was effective because giving a few minutes of your time to a depressed person can have very good results. In this instance my time with the patient did help her to brighten up."

The above abstracts, and earlier identification of a considerable similarity in the role of the nursing assistant and other staff grades, must raise questions about the quantity and content of training given to nursing assistants compared with other grades. It is naive to think that a group of staff can deliver nursing care to patients on a purely physical basis, this being implied in the training, job description and assessment of nursing assistants. An important non-physical element accompanies every element of physical care whether or not the nurse is conscious of that non-physical element. For example, the nurse who washes the face of a depressed patient implies that she cares for that person. Recognition of that caring may be an important part of the total experience of the patient which results in his becoming well.

The use of activities relating to physical care as a vehicle to reach non-physical aspects of care is one which has been commented on by Altschul (1980). The delegation of physical care activities to a group of staff (nursing assistants) who are, ostensibly, only concerned with that area of care will deny non-nursing assistants valuable opportunities to perform non-physical nursing activities via physical care. Furthermore, an act of "simple" physical care gives the opportunity for a number of other more "complex" activities to take place. For example, communication, social, psycho-motor, and intellectual skills can be tested and assessed during this time. It is possible, if not probable, that nursing assistants do make these assessments during the delivery of basic physical care, despite their lack of training in that area.

The pupil nurse, who subsequently becomes an enrolled nurse, also has an almost exclusive physical basis to her nursing education, the six weeks of theory being virtually totally devoted to physical illness and nursing care. As with the nursing assistant, the

enrolled nurse is heavily involved in non-physical care.

Table 19 below adapted from the Report of the Committee on Nursing (1972) p 135 indicates that the majority of ward based nursing staff are in the grades with a largely physical illness/care background, there is no evidence to believe that the numbers have diminished in the last decade.

TABLE 19

Percentage Distribution of Nursing Staff by
Grade at 30th September 1971 Mental Illness
Units in Scotland.

| | % | | |
|---------------------------------------|------|-----|--|
| Nursing officer and above | 5 | 45% | |
| Charge nurse | 17.8 | | |
| Staff nurse | 12.0 | | |
| Student nurse | 15.1 | | |
| Enrolled nurse | 17.8 | 50% | Training largely related to physical care |
| Pupil nurse | 7.4 | | |
| Others (including Nursing assistants) | 24.9 | | |

The questions which emerge from the above discussion include a number with considerable implications for nursing as a profession, and for psychiatric nursing in particular. The extent to which nurse education meets the requirements of the nurse practitioner requires detailed examination from a number of viewpoints. First, the extent to which "specialist" material is emphasised in nurse education is important. For example, is the difference between psychiatric and non-psychiatric nursing great enough to justify separate forms of training? Similarly, are the two nursing specialties similar enough to justify the current large common elements of syllabus content?

At present the major difference in the learning experiences of the three grades of untrained nursing staff (student nurses, pupil nurses and nursing assistants) is the amount of theoretical (classroom) input which each group receives. However, the ratio of theoretical experience to non-theoretical (practical) experience diminishes with time and as the length of the nurses' overall

experience increases. Analysis of the distribution of incidents between staff grades did not suggest that staff activity was significantly different between grades. The function of educational input must therefore be scrutinised.

Second, the current theoretical input to nurse training, is based on inspired guesswork which is unable to take full account of the needs of the patients being nursed, or of the nursing skills required to meet those needs. Bendall (1975) highlighted the discrepancy between what nurses told nurse teachers they would do in an imaginary situation, with what they actually did in real situations. The problem is further underlined by an increasing recognition of the lack of understanding of what constitutes "nursing". Without an understanding of what nursing is, it seems premature to claim that nurses can be "trained".

A related question is the extent to which nurses should be educated to fill the current role of the psychiatric nurse, or to fill the role which a minority think they should be trained to fill. That one minority group in nursing, writers of nursing texts, prescribe a role for nurses which is different from that already filled by them, was reported by Cormack (1975). He compared the roles prescribed for the psychiatric nurse by contemporary writers, and found them to be different from the actual (observed) role.

It is not being suggested that extensive classroom input is redundant because nursing assistants seem to perform relatively well without it, but that its function requires examination. It may be, for example, that those who receive maximum formal educational input relating to mental illness and its related nursing care, pass on that knowledge to others. If this is so, then cessation of the existing arrangement may have serious consequences. Alternatively, it may be that nursing skills, and knowledge, are learned largely or exclusively as a result of the apprenticeship form of experience which nurses, including nursing assistants, are subjected to. If the second alternative is true, then the current almost exclusive emphasis on college based educational input should be examined.

The implications for the professionalism of nursing relate largely to the acquisition of "nursing" skills by those who are not,

or will not be, professionally trained nurses. It is not being argued that what untrained nursing staff are doing at present is "wrong". Rather, it is being suggested that the "professionalism" of nursing must be discussed in the light of the similarity in the role of professional (trained) and non-professional (untrained) nurses.

The role of the psychiatric nurse, as described in the critical incidents, encompassed elements of the four prevailing psychiatric ideologies. The psychotherapeutic ideology was implied in many elements of the classification system in which the critical incidents were placed, encouraging patients to talk about their problems for example. However, there was no evidence to suggest that the role of the psychiatric nurse, as described in the critical incidents, included any formalised psychotherapeutic function. There was no indication that nurses systematically applied psychotherapeutic principles in a planned and consistent fashion to individual patients.

Similarly, the sociotherapeutic ideology was referred to in a number of elements in the classification system, the use of nurse-patient or patient-patient groups for example. There was no evidence to suggest, however, that a structured and systematic application of sociotherapeutic principles formed a part of the role of the nurse.

The behavioural approach to patients' nursing care was alluded to in at least one element of the classification system, in relation to negatively reinforcing patients' pathological behaviour. As with the two ideologies discussed above, there was no evidence to suggest that a systematic and structured application of behavioural principles formed a part of the psychiatric nurses role.

Implicit in the content of many of the critical incidents was a recognition of the potential value of psychotherapeutic, sociotherapeutic and behavioural approaches to patient care. Furthermore, there was much to suggest that nurses were able to make use of these approaches to care in a more systematic and structured manner than used at present.

The fourth major prevailing psychiatric ideology, encompassing the view of the nurse as the doctor's assistant, was often referred

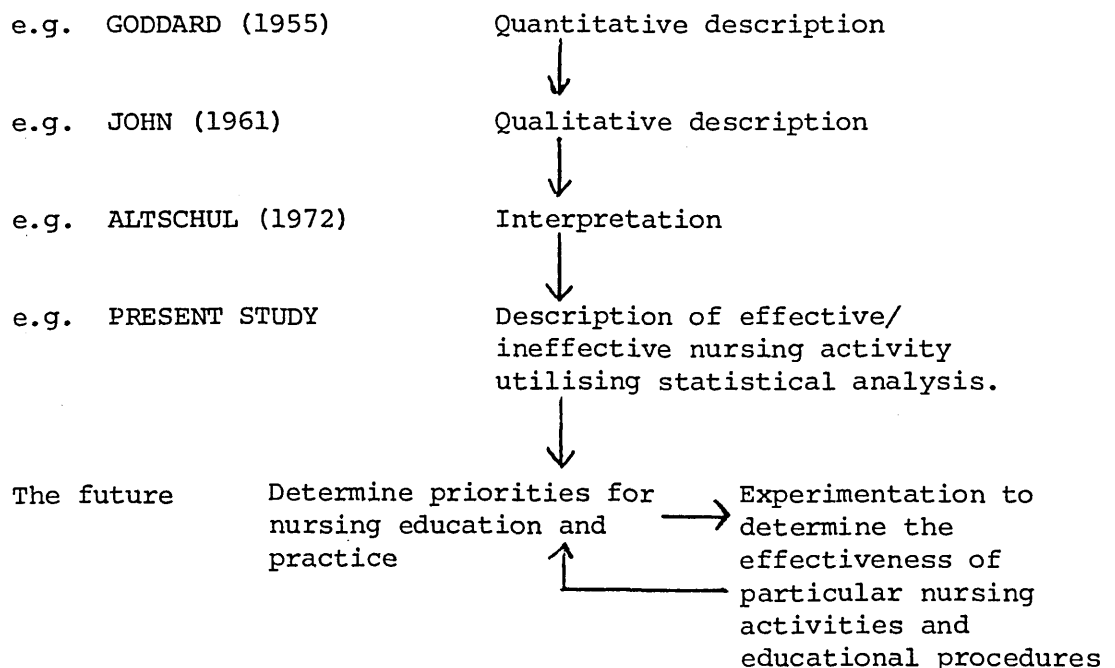
to explicitly in many elements of the system in which the critical incidents were classified. Examples making reference to the medical model are all areas of physical care, including the giving of medications and subsequent observation of patients.

It cannot be concluded from the data that any of the four major prevailing psychiatric ideologies dominate the psychiatric nurses' role. However, it may be concluded that the medical/somatic ideology, as evidenced by relatively common reference to high-visibility functions in the critical incidents, is not an insignificant part of the role of the psychiatric nurse. If the assertion by Brown and Fowler (1971) is true, that high-visibility functions attract greatest reward from high status personnel, then psychiatric nurses are more likely to adopt the medical/somatic model than the other three models which may offer them the opportunity personally to influence patients' mental health.

Relating the results of this study to the findings of other researchers, this work can be seen as part of a continuum, then adding to the work of others in providing a basis for further development.

FIGURE 5

Historical development of research relating to the role of the psychiatric nurse.



Earlier studies of the role of the psychiatric nurse, for example those by Oppenheim and Eeman (1955) and Goddard (1955) were not only descriptive but were largely concerned with the amount of time nurses spent on various activities. While these studies were not designed to make an interpretative examination of the nurses role they are important in that they played a major part in initiating investigation of the work of the psychiatric nurse.

John (1961) rather than just use the "time and motion" approach, included qualitative type data mainly in the form of anecdotal responses from her subjects. This development may be seen as significant and indicative of the increasing recognition that nursing could not be understood simply by a "time and motion" analysis of overt nursing activity. This necessary attempt by John (1961) to add a qualitative (value judgement) dimension to the study achieved some success in that it began to make available the content of nursing activity for examination. However, the work also contains a number of evaluative statements which are not clearly supported by presented evidence and which detract somewhat from the intended description of the psychiatric nurses' role. Further evidence of John's concern to evaluate care is contained in her assertion that nursing care, both physical and psychological, was inadequate. The movement from quantitative to qualitative and evaluative examination of the nurses' role marked an important development which was to receive considerable attention in subsequent years.

Unlike John (1961) and earlier writers, Altschul (1972) focussed attention on one relatively important although narrow aspect of the role of the psychiatric nurse, viz. one-to-one contacts between nurses and patients. The questions raised by Altschul, and which relate to all aspects of psychiatric nursing, imply lack of knowledge relating to the theoretical basis for nursing practice, lack of knowledge of required educational inputs, lack of role conceptualisation and absence of criteria for evaluating nursing care. In describing a research strategy which might answer the above questions Altschul suggests experimentation in which nurses

with different educational preparations have their effectiveness measured by some external criterion other than patients' satisfaction with nursing care.

Towell (1975) in a major sociological examination of the role of the psychiatric nurse sought to achieve a description and understanding of that role. In more specific terms Towell set out to;

- i) investigate the roles of nurses and the nature of their relationships with patients;
- ii) present a description of the understandings, which make up the nursing staff sub-culture, including the perspectives through which the behaviour of patients is interpreted;
- iii) explore the consequences which flow from the utilisation of these perspectives for nurses' action in relation to patients;
- iv) relate the use of these understandings to other features of ward social structure;
- v) examine how these understandings are acquired by new nurses;
- vi) further analyse the relationship between social organisation, treatment culture and patient care;
- vii) make inferences as to the organisation of conditions required for the implementation of particular treatment ideologies;
- viii) show under what social structural conditions and with what functions, the medical and other interpretative models are used in practice by nurses;
- ix) examine the work of the junior nurse and their conception of their role in treatment;
- x) consider the problems engendered for nurses in moving between different types of wards.

This important work concluded that the occupational label "psychiatric nurse" encompassed a cluster of different roles varying radically according to the setting in which these were performed. The major differences found to exist in the three ward settings

were as follows;

ADMISSION WARD Nurses played a key linking role between patients and most aspects of hospital arrangements. They were acting mainly as adjuncts to medical staff.

GERIATRIC WARDS The major activities of nurses focussed on the routine administration of the basic necessities of physical existence for the old people housed there.

THERAPEUTIC COMMUNITY WARD Physical treatment was de-emphasised, and nurses were mainly involved in interaction with patients.

The contradiction between the ^{results}work of Towell (1975) and those of this study which has concluded that the role of the nurse as contained in the classified critical incidents does not differ significantly between specialties is more apparent than real. The specialty differences reported by Towell may have resulted largely from administrative and clinical decisions which subsequently imposed constraints on the nurses working in differing specialties. For example, once the decision is taken to organise a ward as a therapeutic community, the nurse is required to function mainly in the manner described by Towell in that setting. In this context it is important to note that Towell reports that some nurses were able to find satisfaction in this role, and that nurses had considerable problems in resolving the therapeutic community ideology and the more conventional conceptions of the role of the nurse. It would appear, therefore, that the role filled by nurses in this setting may have been imposed by people other than the clinical nurses rather than having been chosen by them, thus placing a constraint on the manner in which they delivered nursing care. In relation to the role of the nurse in the geriatric ward, different, although equally important, constraints may have existed. These constraints result from a perceived shortage of nursing staff, lack of time to talk to patients, lack of ward teaching and the amount of time nurses are required to spend on domestic work all of which were identified by Towell as the major problems reported by nurses.

The present study reports the activity required to be undertaken by nurses in order to provide, in the opinion of the respondents, effective nursing care. It was reported that the difference of the nurses' role between the three major specialties was minimal and only a matter of emphasis. Thus, if the constraints imposed on nurses in Towell's study had not been present the apparent conflict between the two studies may have been diminished.

The work of Towell (1975), therefore, played an important part in developing a description and understanding of psychiatric nursing from a sociological perspective in a context of administrative and clinical constraints. It may be that the specialty differences reported by Towell (1975) are a function of the prevailing, perhaps imposed, psychiatric ideology within which nurses work, rather than a difference which resulted from choice. It is important to note that this study imposed no limitations, other than those described in Appendix 5, on the nature of the examples of effective and ineffective nursing which respondents could provide.

In a further descriptive study Cormack (1976) focussed on the role of the charge nurse in acute admission wards of psychiatric hospitals and compared their actual (observed) role with that prescribed in the literature. It was concluded that, while the observed and prescribed role were not the same, there were a number of observed role elements which were potentially therapeutic. One example of such a therapeutic role element is "being available" to patients, an activity given considerable importance by patients.

More recently Sladden (1979) presented a descriptive study of a community psychiatric nursing service, a study not without relevance to psychiatric nursing generally. It was concluded that nurses operating the service, which was found to be functioning as a mobile arm of the parent hospital, lacked a fully legitimised role. A major source of ambiguity and inconsistency lay in a failure to relate the service and its objectives to a consistent model of what community care should mean in the context of psychiatry. The conclusions arrived at by Sladden (1979) reflect those previously arrived at in relation to hospital based psychiatric nurses, indeed, it would have been very surprising if the findings had been different

bearing in mind the common origins, training and development of both groups.

The present study has combined a descriptive approach and a limited evaluative approach in examining the role of the psychiatric nurse. A description of role elements is presented which, it is hypothesised, can be the basis of a description of effective nursing activity. A feature of the role elements is that they represent actual nursing activities which have been performed and which, in the view of the respondents, constituted effective nursing. Implicit in this description of nursing is the assertion that each item represents effective nursing. This assertion has not been tested in this study, rather it has been developed as a result of opinion obtained from individuals involved in, or knowledgeable of, the practice of psychiatric nursing. These hypotheses would need to be experimentally tested. A fuller discussion of how this may be achieved is presented in the next chapter.

CONCLUSION AND RECOMMENDATIONS

The principal objective of this work, to describe the role of the ward based psychiatric nurse, depended on the observation and subsequent description of naturally occurring behaviour. The nurse role is described as it is, rather than as it should be, or how reporters think it is. Data were collected using the critical incident technique described by Flanagan (1954). As has been mentioned, it is not being claimed that the 4477 critical incidents represent a totally comprehensive description of the work of the ward based psychiatric nurse, it is recognised that the role of the nurse is no less than that contained in the data.

A total of 4477 critical incidents were collected from 1164 staff and patient respondents in eleven Scottish psychiatric hospitals. The majority of incidents (96%) related to one or other of the six staff grades reported on, the remaining 181 (4%) related to all six staff grades, a total of 5392 nursing staff being reported on.

The critical incidents were classified in a system devised specifically for that purpose, the classified incidents then constituted a description of the role of the psychiatric nurse. Although all incidents were classified by the writer, samples were also classified by two independent judges and the level of inter-rater reliability measured and found to be significant.

The classified incidents were analysed to determine the extent to which the role of the psychiatric nurse differed between;

Shifts (night and day)

Specialties (geriatric, long stay and acute)

Staff grades (charge nurse, staff nurse, enrolled nurse, student nurse, pupil nurse and nursing assistants)

The purpose of the above analysis was to establish the extent to which nurses of differing grades, working on differing shifts or in differing specialties, may require a differing educational input or assessment system. Analysis of the data suggested that shift, specialty and grade differences were minimal and that the role of the psychiatric nurse, as described in the classified incidents,

was applicable to both shifts, the three specialties and all six staff grades.

The classified critical incidents were used to further four further aims of the study;

- (i) To obtain an objective basis by which to assess patients' nursing needs.
- (ii) To formulate criteria by which to measure the effectiveness of the work of the psychiatric nurse.
- (iii) To provide an objective appraisal of the educational needs of the psychiatric nurse.
- (iv) To provide a basis for an objective assessment of nursing performance.

The implications of (i) to (iv) above were discussed as they relate to the education of the psychiatric nurse.

Towell (1975) commented on the relative lack of systematic study of the work of the psychiatric nurse; an observation which continues to hold good. This study has added to the literature relating to the role of the ward based psychiatric nurse, but cannot claim to have made a definite statement about that role for the following reasons. First there is the known discrepancy between what nurses say they will do under certain circumstances, and what they actually do under these circumstances (See Bendall 1975). While the data collection tool used, Flanagan's critical incident technique, cannot claim to have completely eliminated this problem, there are reasons to believe that it reduced the potential discrepancy between "saying" and "doing". Flanagan (1952a) advocated the collection of facts rather than opinions as the first essential of a good procedure for evaluating performance, although recognising in another paper Flanagan (1952b), that it was quite impossible to develop scientific knowledge without making judgements. Blum and Naylor (1968) viewed the critical incident technique as minimising the gap between expressed and actual performance claiming that its advantage was in that it used actual job behaviours, rather than opinions.

The second limitation of the study relates to the comprehensiveness of the data base which is used to describe the role of the nurse and the differences between grades, shifts and specialties. Although

the number of collected incidents was large, and obtained from a broad spectrum of respondents it may be that some aspects of the nurses' role were not reported on. Replication of this work, which is undoubtedly required, could result in a more comprehensive description and understanding of the role of the nurse by, for example;

- (i) obtaining critical incidents from patients' relatives
- (ii) obtaining critical incidents from patients with whom a one-to-one relationship had been established over a period of time.
- (iii) obtaining critical incidents from a variety of nurses' co-workers, including psychologists, social workers, occupational therapists, pharmacists, hospital chaplains, ambulance drivers and dieticians.

A third limitation involves the inter-rater reliability relating to a number of Sub-categories. The levels of agreement, although statistically significant, were sometimes unconvincing from a "practical" viewpoint. The extent to which these levels of agreement should be accepted or rejected requires to be examined via replication of this study.

A fourth limitation of the work involves the difficulty which nurses of all grades and levels of experience have in describing individual and specific elements of their role. This may either reflect uncertainty about their role or problems relating to making a written description of it. In any event this difficulty is of particular importance when the data collection tool relies heavily on the ability of respondents to make a specific and accurate description of their role.

Finally, in relation to whether nursing behaviours are effective or ineffective, there can be no doubt that nursing will continue to seek an answer to this question for some time. The recognition of inability to evaluate nursing care is not new although it is being increasingly referred to. Abdellah and Levine (1965) in a discussion of the impact of research in nursing concluded that;

"These studies will have little decisive impact on the improvement of patient care if there are no adequate criterion measures to evaluate effects of changed practice upon patient care The lack of criterion measures in nursing places a

partial blindfold on the nurse " p 282

More recently Lee (1979) was even more critical of the lack of evaluation techniques when she wrote;

"How does the nursing sister know that care is good, poor, fair, unsatisfactory? Often little more than gut reaction or intuition is used as a measure." p 133

This study has relied exclusively on views of nurses, doctors and patients to describe effective and ineffective nursing care as it related to actual instances of nursing activity. The limitation of this approach is that it cannot guarantee the validity of these views, including those expressed by professional nurses. However, it can be argued that the approach used in this study, relying as it did on actual nursing activity, is an improvement over using opinions based on hypothetical situations, or, as reported by Alaszewski (1978) evaluating patient care by examining staff or resource inputs and equating more staff or resources with "better" care.

Despite the above limitations, it is suggested that this study has contributed to an understanding of psychiatric nursing generally, and to the specific objectives of the work in particular. However, it is recommended that vigorous research-based study of what constitutes "psychiatric nursing" continue to try and resolve the inconsistencies which this work found relating to;

- (a) the actual role of the psychiatric nurse;
- (b) their job descriptions;
- (c) their education; and
- (d) their assessment criteria.

While it is arguable that (a) to (d) above should contain considerable common material, this was not found to be so. It is suggested that further examination of the causes of such differences should be undertaken and, if found to be unjustified, they should be reduced. The apparent discrepancies may reflect the diverse, and largely unrelated, bodies which are responsible for the education, assessment, role determination and job descriptions relating to nursing staff. For example, while the General Nursing Council for Scotland determine the educational input for student and pupil nurses, the Scottish

Home and Health Department recommend the educational input for nursing assistants. Similarly, while the nature of nursing practice tends to be determined locally, for example within the hospital in which the student or pupil nurse is working, educational input is determined at national level by the General Nursing Council for Scotland. Job descriptions for staff, other than nurses in training, emanate from one of a number of parts of the nursing administrative system ranging from the individual hospital to the Scottish Home and Health Department. A further organisations, the Scottish Nursing Staff Committee, is involved in determining the assessment criteria and systems applied to trained nursing staff. It is suggested that stronger links between those organisations involved in the education, assessment, preparation of job descriptions and nursing practice would minimise the discrepancies which were found to exist.

At present, the links between nurse educators and nurse practitioners is tenuous, as is the link between those who formulate educational policies and strategies and those who implement them. The dichotomy which exists between nurse educators and practitioners is one which has often been commented on in recent years, and does not appear to be reducing. The associated dichotomy between what nurses are taught to do, and what they actually do was highlighted in particular by Bendall (1975) who demonstrated that considerable difference existed between what nurses say (under examination conditions) they will do, and what they actually do in practical situations. This gap in nursing theory and practice requires to be resolved and any examination of other models of education might be profitably undertaken. Organisation of nurse education on the pattern used in the education of medical staff may reduce the theory and practice gap in that educators and practitioners in medicine are frequently one and the same. Limited experimentation with this form of linking education with practice is already underway at some centres including the University of Manchester where a lecturer also holds the post of charge nurse at a local hospital.

The division between nurse education and practice raises a further question in relation to the means of facilitating innovation

in nursing practice. For example, it is unclear at present if nurses are trained to undertake a specific role, or if the nature of their role is determined by their training. If innovation is education based, it may be impractical or be resisted by nurse practitioners. This resistance was implied in a recent paper by Kirwin (1980) in relation to the inability of nurse educators to cause the nursing process (a systematic means of planning, implementing and evaluating nursing care) to develop from a teaching tool to one with a practical application.

Finally, the gap between education and practice prevents a large amount of potential teaching material from being used. Indeed, it might be argued that many aspects of nursing care can only be fully understood in relation to concurrent exposure to practical nursing experiences. For example, a nurse may have great difficulty in learning how to communicate with a depressed patient without controlled and educationally supervised exposure to that experience in a practical situation.

Currently, decisions about the content of the educational input offered to nurses in training ^{do} does not result from a systematic examination of the educational needs of the learners. At best, ~~it~~ ^{they} depend on the informed opinion of nurses, many of whom will have had little recent experience in nursing practice. Unless such a systematic examination of nursing practice, and therefore of the required educational input, is undertaken, it is probable that nursing education will continue to fail to correspond with nursing practice.

In relation to nurse education a description of the educational needs of ward based psychiatric nurses was presented (See p 211-215). This and other analysis and presentation of the data has been undertaken in such a way as to achieve most clearly the major objective of this study; to "describe the role/s of ward based psychiatric nurses in a sample of eleven Scottish psychiatric hospitals".

The data also clearly demonstrate, within the limits imposed by the chosen research method, the presence or absence of shift, specialty or grade differences as these relate to the psychiatric nurses' role.

The presented data also clearly reflect the further four related aims of the study:

- (i) To obtain an objective basis by which to assess patients' nursing needs.
- (ii) To formulate criteria by which to measure the effectiveness of the work of the psychiatric nurse.
- (iii) To provide an objective appraisal of the educational needs of the psychiatric nurse.
- (iv) To provide a basis for an objective assessment of nursing performance.

This has been achieved in the construction of FIGURE 3; (p 202)

- (i) Framework of patients' potential nursing needs.
- (ii) Framework for evaluation of nursing care
and

FIGURE 4; (p 211)

- (i) Educational needs of ward based psychiatric nurses.
- (ii) Schedule for the assessment of ward based psychiatric nurses.

This work did not seek to establish priorities for educational input, or to externally validate the relative importance of role elements derived from the classified critical incidents. However, it is proposed that any such establishment of educational priorities, and the means of externally validating them, can only be achieved following the construction of a description of what nursing is. Such a description is contained within this work and is seen as a precursor to further work which will examine priorities and externally validate the outcome of educational input based on these priorities. The following discussion relates to how such priorities may be identified, and the means of externally validating them.

It must be recognized that the frequency with which incidents appear in one or other part of the classification system does not reflect their relative importance or their priority for nurse education or patient care. For example an area of functioning

may have been reported on more often than some other because the former was more obvious or easier to describe than the latter. Similarly, a relatively important activity such as observing a depressed patient who may commit suicide may be reported on less frequently than an activity with a more overt purpose, ordering ward food supplied for example, which also has a much more definite "beginning" and "end" and therefore becomes easier to relate in the form of an incident. Some nurses also had difficulty in providing examples of critical incidents because they did not perceive their ordinary "chores" as being important or noteworthy.

The classified incidents represent a description of what nursing is and what each of the six grades of nurses do, rather than a description of levels of importance for education, patient care or the assessment of nurses' knowledge or skill. Arguably, all items in the framework should be taught to all nurses who perform the activity. However, the establishment of priorities has to be considered to optimise the impact of finite educational resources. It is suggested that the following strategies may assist in identifying those elements with a relatively high or low priority.

First the data need to be examined in relation to each staff grade and the question asked "Is this activity a legitimate part of the role of that grade of nurse?" What the data presently show is what nurses were reported as actually doing in terms of effective and ineffective functioning. It is for nurses generally, including clinicians and educators, to judge whether or not these activities should continue to form part of the work of that grade of nurse.

A second related consideration concerns role elements which may not have been included in the data but which are nevertheless considered to be a legitimate part of the psychiatric nurses' role. If such role elements exist they should be included in a revised framework. Decisions of this kind should be made urgently and be taken following full discussion within psychiatric nursing generally, and those who teach and practice in particular. Such a discussion must extend to a detailed consideration of the role of the nurse caring for the mentally ill. If a discrepancy exists between what the role of the nurse is, as described in the classified incidents,

and what psychiatric nurses determine it to be, a solution to the problem should be vigorously sought. Such a solution would clearly have important implications for nurse education in terms of both theory and clinical experience.

Third, the question of priority may be examined by submitting the classified incidents to examination by nurses with a view to reaching a consensus of opinion. Clearly, such an examination of the data could be undertaken in a number of ways including the determining of priorities by a committee of nurse clinicians, educators, doctors, patients and other specialists caring for the mentally ill. A formal research based exercise in which a large number of nurses are asked to rank the role elements in level of priority would also be of value in establishing priorities. A broad description of what psychiatric nursing is, such as is contained in this work, is a pre-requisite to determining priorities.

Fourth, the level of current effectiveness or ineffectiveness with which each activity is performed will partly determine the priority given to it in terms of educational input. While considerable opinion exists with regard to how well or poorly nursing activities are performed, there is little research based evidence to support the opinion. The existing inappropriate and relatively non-specific nature of assessment criteria used in nursing make it difficult to determine how well nurses perform their work. Clearly the use of more appropriate, comprehensive and specific assessment criteria can be developed from the classified incidents and used to determine those activities which are performed relatively poorly. Such an examination of performance would assist in identifying educational priorities. The extent to which activities were performed effectively or ineffectively in this work could form a legitimate part of such an exercise.

Finally, there remains very little information on what constitutes good psychiatric nursing other than the opinions of patients, nurses and other well informed people. While the classified incidents constitute a description of effective and ineffective nursing from a large number of respondents, it remains well informed opinion. While priorities for patient care can be determined by examining the

description of nursing, these can only be based on professional judgement. Future examination of what constitutes good nursing practice must include an experimental approach with nursing care being examined in relation to pre-determined criteria. For example, a group of nurses may be taught how to make therapeutic use of the environment and their performance in relation to this activity examined and compared with a similar group of nurses who were not exposed to this additional educational experience. The results of such an experiment would also require examination in relation to patient outcome with correlation of nursing performance against predetermined patient outcome. For example, the extent to which nurses' therapeutic use of the environment influenced patients orientation for place or interaction rate could be examined, and compared with a group of patients cared for by nurses not exposed to such additional educational experience. The writer is not unaware of potential problems associated with measuring effective outcome for patients against the effectiveness of nursing performance. While this may be particularly true in relation to the mentally ill person who tend to experience "low visibility" problems such as those relating to trust and anxiety, all areas of nursing are recognising the need to describe criteria by which the effectiveness of their care can be measured.

However, the evaluation of psychiatric nursing care, although difficult, is not impossible as has been demonstrated by the work of Marks et al (1973). It is suggested that the development of psychiatric nursing research must relate more clearly to the setting and testing of specific nursing goals relating to individual case-centred experimentation of the A - B - A variety. For example, a patient with a specific nursing care need is identified and studied under baseline (existing) conditions (phase A). A specific nursing procedure designed to influence the identified problem is introduced and evaluated (phase B). The procedure is withdrawn and the patient observed to determine whether his behaviour returns to baseline level (phase A).

Such a progression would move nursing research from the present largely descriptive state toward a correlative approach which would

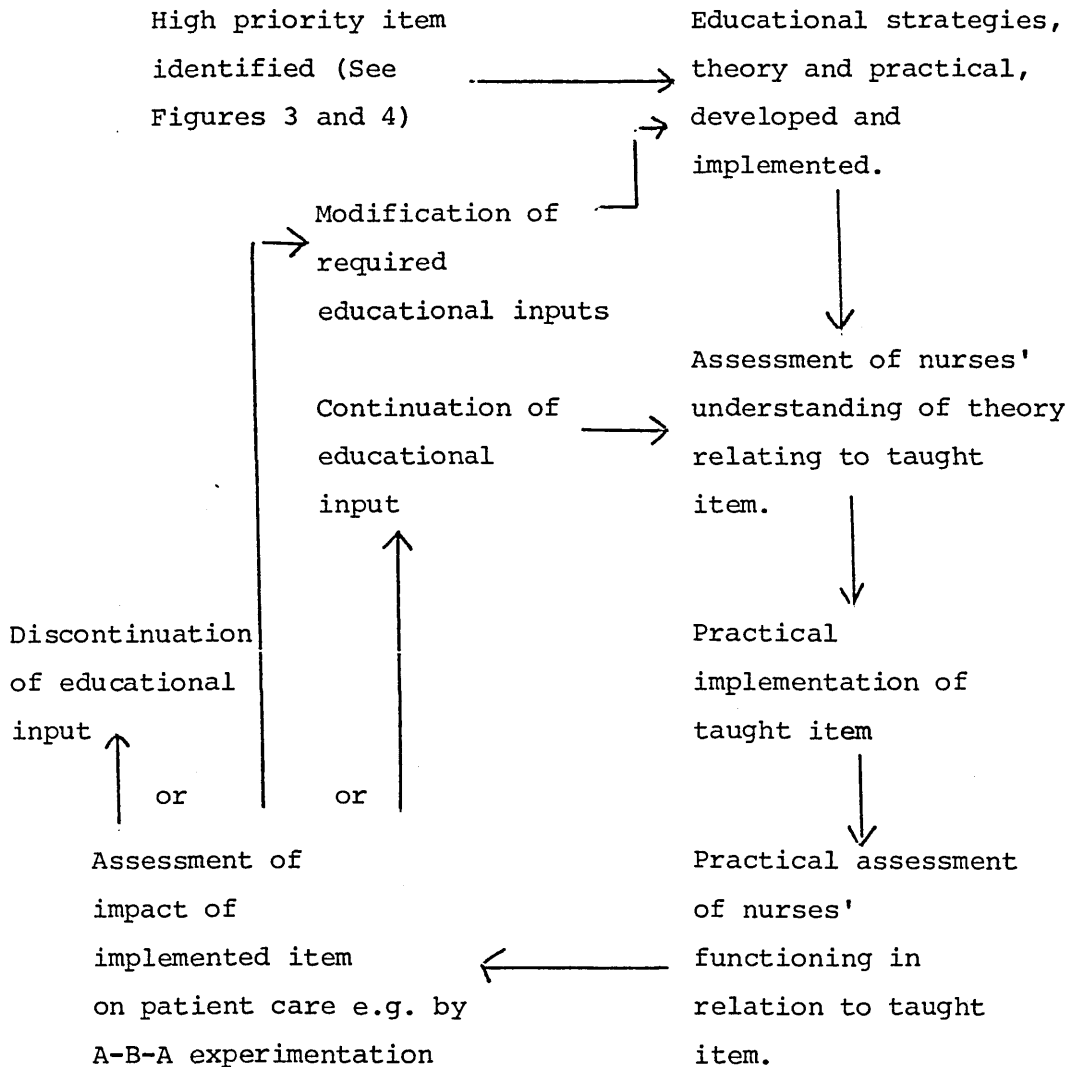
seek to answer "which nursing performances relate to positive patient outcomes", thus establishing tentative priorities for nursing education. Next, experimentation would seek to establish the precise effects of specific nursing procedures on patients.

Finally, the use of experimentally determined priorities are necessary to test the application of non-nursing theories of therapeutic intervention, psychotherapy for example, to nursing circumstances and to develop a body of experimentally based knowledge from which nursing theory will develop.

In short, the time may well be right for a move in psychiatric nursing research away from descriptive toward experimental research. The outcome of such experimentation relating to specific items of care should be reflected by inclusion in or exclusion from educational input. Experimentation with individual items of care, educational input and nursing assessment, rather than with care generally would facilitate evaluation and may be expressed in the following model.

FIGURE 6

Model for experimentally implementing and evaluating
itmes of nursing care.



As individual items contained in the framework of classified incidents are experimentally evaluated in terms of pre-determined criteria, they may continue to form part of the nurses' role or be excluded from it.

Any examination of nurses' educational needs and subsequent evaluation of performance in terms of patient outcome must take account of the need to have a diverse group of nurses caring for hospitalised patients. This requires to be questioned and subjected to systematic examination. It may be that, by a process of

division of labour, a need exists for the six existing grades, however, this study has not found significant differences in the nursing care provided by the varying groups. That nursing skill had less to do with training and more to do with the individual's "capabilities, personality and interests", was suggested by Morgan and Moreno (1973). If this is so then the role of nurse training may have to be considered as being secondary to personnel selection.

Data collection for this study, relying as it did on nurses being able to describe specific aspects of care delivered to individual patients, highlighted the difficulty which nurses have in describing nursing care in individual and specific terms. The problems which nurses have in evaluating the outcome of their work was also made obvious, as was a tendency of nurses to underestimate the importance of "basic", "routine", or "ordinary" care. These problems are all part of the increasing realisation of nurses' inability to describe the nature of nursing. This problem requires to be made known to nurses generally with a view to stimulating personal, and more formal, attempts to describe the nature and content of nursing as a professional activity.

Inspiration for this work came from a number of sources including the literature relating to the lack of knowledge about the psychiatric nurses' role. It is hoped that it will go some way toward answering the question "what is the psychiatric nurses' role?", and inspire others to continue to follow the recommendation of Callista (1970) who wrote;

"As medical science makes strides in the prevention and treatment of disease, nursing needs to be able to identify its own and particular area of practice within the health field." p 42

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The published paper cited below has been removed from the e-thesis due to copyright restrictions:

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APPENDIX 2

Explanatory letter to nurses and request for critical incidents (first pilot study)

Research Study - The Role of the Psychiatric Nurse

I am continuing a study of the work of the psychiatric nurse and am seeking the assistance of a number of people on a voluntary basis.

Your participation in the study will help to achieve a better understanding of what psychiatric nurses do and, hopefully, will result, in the long term, of better patient care. I would like to emphasise that all information will be treated in absolute confidence and the names of staff must never appear on the data collection forms.

I enclose 20 forms and would request that you fill them up at your convenience, returning them to me when you have done so. You will see that the white forms ask for descriptions of EFFECTIVE nursing activity, while the coloured forms ask for description of INEFFECTIVE nursing activity. Please try and include some descriptions of your own EFFECTIVE and INEFFECTIVE nursing activity. When all the forms have been filled in they can be returned to me (using the envelope provided) via the NURSING ADMINISTRATION OFFICE.

I also enclose four forms which contain examples of how you might describe EFFECTIVE and INEFFECTIVE nursing activity. Please bear in mind that "nursing activity" covers many areas including physical care, administration, observation, teaching, staff allocation, psychological care, dealing with relatives, compiling reports and so on. Your examples can relate to any areas of nursing activity you may choose.

Thank you very much for your co-operation.

Yours sincerely,

Desmond Cormack
Lecturer in Nursing Studies

APPENDIX 3a

Form used for collecting effective critical incidents
(pilot and major study)

1. Nursing specialty being described: ACUTE/SHORT STAY NURSING
2. Grade of reporting nurse
3. Grade of nurse participating in described activity.
If self, please write "self"
4. Please describe a time when a nurse did something which you
feel should be encouraged because it seemed to be very
EFFECTIVE.
 - A. What were the events leading up to the activity?
.....
.....
.....
.....
 - B. What did the nurse do that seemed so EFFECTIVE?
.....
.....
.....
.....
 - C. Why was the activity so EFFECTIVE?
.....
.....
.....
.....
5. How many days ago did the activity occur?

APPENDIX 3b

Form used for collecting ineffective critical incidents
(pilot and major study)

1. Nursing specialty being described: GERIATRIC NURSING
2. Grade of reporting nurse
3. Grade of nurse participating in described activity.
If self, please write "self"
4. Please describe a time when a nurse did something which you feel
should be discouraged because it seemed to be very INEFFECTIVE.
 - A. What were the events leading up to the activity?
.....
.....
.....
.....
 - B. What did the nurse do that seemed so INEFFECTIVE?
.....
.....
.....
.....
 - C. Why was the activity so INEFFECTIVE?
.....
.....
.....
.....
5. How many days ago did the activity occur?

Example of completed data collection form (first pilot study)

1. Nursing specialty being described: ANY (Example)
2. Grade of reporting nurse? *Student Nurse*
3. Grade of nurse participating in described activity.
If self, please write "self" *Staff Nurse*
4. Please describe a time when a nurse did something which you feel should be discouraged because it seemed to be INEFFECTIVE.
 - A. What were the events leading up to the activity?
A patient was having some difficulty in taking her skirt off
before going to bed. She called to a nurse and asked if she
could untie her zip for her, saying she could "manage the rest".

 - B. What did the nurse do that seemed so INEFFECTIVE?
The nurse came over and undressed the patient knowing that she
required much more help than she had requested. During this time
the nurse did not talk to the patient or explain why she was
giving much more help than was asked for.

 - C. Why was the activity so INEFFECTIVE?
After the zip had been untied the patient became restive and
restless. If the nurse had talked to the patient and explained
why extra help was being given this may have prevented the patient
from becoming restless and restive.

5. How many days ago did the activity occur? *One*

APPENDIX 4b

Example of completed data collection form (first pilor study)

1. Nursing specialty being described: ANY (Example)
2. Grade of reporting nurse? *Enrolled Nurse*
3. Grade of nurse participating in described activity.
If self, please write "self" *Nursing Assistant*
4. Please describe a time when a nurse did something which you feel should be encouraged because it seemed to be very EFFECTIVE.
 - A. What were the events leading up to the activity?
A patient was having some difficulty in taking her skirt off
.....
before going to bed. She called to a nurse and asked if she
.....
could untie her zip, saying that she could "manage the rest".
.....
.....
 - B. What did the nurse do that seemed so EFFECTIVE?
The nurse came over and undressed the patient.
.....
.....
.....
.....
 - C. Why was the activity so EFFECTIVE?
The nurse knew that the patient was unable to undress herself.
.....
Rather than have the patient frequently ask for help the nurse
.....
responded to the patient's request by giving her as much help
.....
as she required.
.....
5. How many days ago did the activity occur? *Today*

APPENDIX 4c

Example of completed data collection form (first pilot study)

1. Nursing specialty being described: ANY (Example)
2. Grade of reporting nurse? *Student Nurse*
3. Grade of nurse participating in described activity.
If self, please write "self" *Charge Nurse*
4. Please describe a time when a nurse did something which you feel should be encouraged because it seemed to be very EFFECTIVE.
 - A. What were the events leading up to the activity?
A relative asked for an interview with the charge nurse, she
wanted to discuss how well her husband was progressing in
hospital.

 - B. What did the nurse do that seemed so EFFECTIVE?
The charge nurse, with the relatives permission, invited me to
"sit in" on the interview.

 - C. Why was the activity so EFFECTIVE?
I was shown an example of how to communicate with a patient's
relative. This was something I had been told about before but
never shown.

5. How many days ago did the activity occur? *Two*

APPENDIX 4d

Example of completed data collection form (first pilot study)

1. Nursing specialty being described: ANY (Example)
2. Grade of reporting nurse? *Staff Nurse*
3. Grade of nurse participating in described activity.
If self, please write "self" *Pupil Nurse*
4. Please describe a time when a nurse did something which you feel should be discouraged because it seemed to be INEFFECTIVE.
 - A. What were the events leading up to the activity.
A patient had been disturbed and restless for much of the night. Eventually she got up and reported to the pupil nurse that she could not sleep......
.....
 - B. What did the nurse do that seemed so INEFFECTIVE?
The nurse told the patient she was disturbing other patients on the ward and that she should go back to bed right away......
.....
.....
 - C. Why was the activity so INEFFECTIVE?
The patient went back to bed but was still unable to sleep......
The nurse didn't try to establish why the patient was having difficulty sleeping......
.....
5. How many days ago did the activity occur? *Two*

APPENDIX 5

Explanatory letter to nurses and request for critical incidents (second pilot and major study)

Dear Nurse,

I am continuing a study of the work of the psychiatric nurse and am seeking the assistance of a number of people on a voluntary and confidential basis.

Your participation in the study will help to achieve a better understanding of what psychiatric nurses do and, hopefully, will result in better patient care. I would like to stress that all information will be treated in absolute confidence and the names of staff or patients should never appear on the data collection forms.

I provide four forms and request that you fill them up during the next twenty to thirty minutes.

You will see that the white forms ask for descriptions of EFFECTIVE nursing, while the coloured forms ask for descriptions of INEFFECTIVE nursing activity.

Please bear in mind that "nursing activity" covers many areas including physical care, psychological care, administration, staff allocation, dealing with relatives, compiling reports etc. Your examples can relate to any areas of nursing activity you choose.

Finally, I am interested only in nurses who work in wards, up to and including Charge Nurse grade. I only require examples of nursing activity in the sub-specialty referred to in question one of the forms.

Thanking you in anticipation of your co-operation.

Yours sincerely,

Desmond Cormack
Lecturer in Nursing Studies

APPENDIX 6

Explanatory letter to doctors and request for critical incidents
(second pilot and major study)

Dear Doctor,

I am continuing a study of the work of the psychiatric nurse and am seeking the assistance of a number of people on a voluntary and confidential basis.

Your participation in the study will help to achieve a better understanding of what psychiatric nurses do and, hopefully, will result in better patient care. I would like to stress that all information will be treated in absolute confidence and the names of staff or patients should never appear on the data collection forms.

I enclose four forms and request that you fill them up at your convenience, returning them to me in the internal mailing system when you have done so; I enclose an addressed envelope for that purpose.

You will see that the white forms ask for descriptions of EFFECTIVE nursing, while the coloured forms ask for descriptions of INEFFECTIVE nursing activity.

Please bear in mind that "nursing activity" covers many areas including physical care, psychological care, administration, staff allocation, dealing with relatives, compiling reports etc. Your examples can relate to any areas of nursing activity you choose.

Finally, I am interested only in nurses who work in wards, up to and including Charge Nurse grade. I only require examples of nursing activity in the sub-specialty referred to in question one of the forms.

Thanking you in anticipation of your co-operation.

Yours sincerely,

Desmond Cormack
Lecturer in Nursing Studies

APPENDIX 7a

Example of data collection form sent to doctors
(second pilot and major study)

1. Nursing specialty being described: LONG STAY AMBULANT NURSING
2. Grade of reporting doctor
3. Grade of nurse participating in described activity
4. Please describe a time when a nurse did something which you feel should be encouraged because it seemed to be very EFFECTIVE.
 - A. What were the events leading up to the activity?
.....
.....
.....
.....
 - B. What did the nurse do that seemed so EFFECTIVE?
.....
.....
.....
.....
 - C. Why was the activity so EFFECTIVE?
.....
.....
.....
.....
5. How many days ago did the activity occur?

APPENDIX 7b

Example of data collection form sent to doctors
(second pilot and major study)

1. Nursing specialty being described: LONG STAY AMBULANT NURSING
2. Grade of reporting doctor
3. Grade of nurse participating in described activity
4. Please describe a time when a nurse did something which you feel should be discouraged because it seemed to be very INEFFECTIVE
 - A. What were the events leading up to the activity?
.....
.....
.....
.....
 - B. What did the nurse do that seemed so INEFFECTIVE?
.....
.....
.....
.....
 - C. Why was the activity so INEFFECTIVE?
.....
.....
.....
.....
5. How many days ago did the activity occur?

APPENDIX 8

Reminder letter sent to doctors (second pilot and major study)

Dear Doctor,

Some weeks ago I sent you a request for assistance with my research into the role of the psychiatric nurse.

A number of responses have been received from the medical staff, however a few have not yet been returned. If you have not yet sent me your reply please feel free to do so using the envelope provided with the original request.

I look forward to receiving your contribution in the knowledge that the views of medical colleagues will help to provide a more complete picture of the role of the psychiatric nurse.

Thanking you in anticipation of your help.

Yours sincerely,

Desmond Cormack
Lecturer in Nursing Studies

APPENDIX 9

Letter to doctors requesting that their patients be included
in the study

Dear Doctor,

I write to ask permission to undertake data collection for a nursing research project at Hospital X. Hospital X would then be included in my sample of Scottish Psychiatric Hospitals.

The research is designed to provide data which will improve the present understanding of the role of the psychiatric nurse in the three major specialties;

- (1) Acute admission nursing
- (2) Psychogeriatric nursing
- (3) Long stay/ambulant nursing

I am interested in the work of the following grades of ward based staff on both day and night duty:

- (1) Nursing assistants
- (2) Pupil nurses
- (3) Student nurses
- (4) Enrolled nurses
- (5) Staff nurses
- (6) Charge nurses

It is proposed that the following groups of staff and patients be invited, on a voluntary and confidential basis, to provide data using the enclosed form.

- (1) Nursing assistants
- (2) Pupil nurses
- (3) Student nurses
- (4) Enrolled nurses
- (5) Staff nurses
- (6) Charge nurses
- (7) Nursing officers
- (8) Medical staff
- (9) Patients in admission wards
- (10) Patients in long stay/ambulant wards

Groups 1 to 8 above would be invited to fill in four forms (two white and two coloured). Groups 9 and 10 would be invited to fill in two forms (one white and one coloured). Only those patients who, at the time of data collection, were thought to be able to participate would be invited to do so. I enclose letters of explanation which would be given to the medical and nursing staff, a similar verbal explanation being given to patients by me.

In order to collect data I would with permission, spend one week at Hospital X sometime this summer. Data collection would be timed to prevent interference with patient care and nursing activity. Medical staff who wish to participate could do so at their convenience.

I have communicated with the Divisional Nursing Officer who feels the request to be reasonable from the nursing viewpoint.

I hope you will give this request your favourable consideration.

Yours sincerely,

Desmond Cormack
Lecturer in Nursing Studies

Making use of unsolicited research data

(This paper has been accepted for publication by the Journal of Advanced Nursing and will be published in 1981)

Researchers who collect survey type data are, understandably primarily concerned with the "official" responses to their requests for data. If the request is fruitful, and the response rate acceptable, the "unofficial" and unsolicited responses of the respondent may go unrecorded. For example if a nurse is asked to "Describe how an intra-muscular injection should be given", her (official) response will be recorded by the researcher. However, if the response was formulated with great difficulty, a fact which may have some importance, this may not be expressed or, if expressed, not recorded. The importance of such "unofficial" and unsolicited data can be looked at from a number of viewpoints.

First, information which qualifies the response may be obtained. For example, a respondent may describe how an intramuscular injection should be given but add "That is how I was taught to do it, but another method is used at this hospital".

Second, information which enables a better understanding of the personal context of the response may be obtained. For example, a nurse might add "I found it very difficult to answer the questions. I am just not used to describing my work, I would have found it much easier to show you".

Third, information which enables a better understanding of the social and organisational context in which the responses are made may be obtained. For example, a nurse might add "I know the answer is supposed to be confidential, but I have a feeling that the nursing administration at this hospital will see my response".

Such comments, "unofficial", spontaneous and in addition to the data being collected, may add to an understanding of the research process generally, the general area being researched, or to the specific subject area. This paper argues for such comments to be actively encouraged and recorded whenever possible. If not formally

taken account of, they should not be ignored.

The writer recently collected data from staff and patient respondents in eleven Scottish psychiatric hospitals. Data were collected using the Critical Incident Technique described by Flanagan (1954) who described a critical incident as being;

"..... any observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act an incident must occur in a situation where the purpose or intent of the act seems fairly clear to the observer and where its consequences are sufficiently definite to leave little doubt concerning its effects." p 327

The number of critical incidents collected satisfied the needs of the research study of which they formed a crucial part. The technique has been used to study the work of a number of groups ranging from air-crews, Miller (1947) to grocery store managers, Anderson and Nilsson (1964). Considerable use of the critical incident technique has been made in a variety of nursing areas. Examples are; nurses' perception of their role, Rimon (1979), evaluating nursing student performance, Flanagan *et al.* (1963), evaluation of staff nurses, Rosen and Abraham (1963) and as a problem solving tool in nursing, Fivars and Gonsell (1966). An important example of its application in studying the role of the psychiatric nurse is contained in a three volume work published by the American Institute for Research and written by Jacobs *et al.* (1973).

Potential respondents were requested to provide critical incidents, the nature of the request is presented in Appendix 5. Each respondent was asked to complete an equal number of forms relating to EFFECTIVE and INEFFECTIVE activity, staff being asked to provide two of each and patients one of each (See Appendices 3a and 3b). The data collection forms and explanation were altered slightly depending on the nursing specialty being described, and whether staff or patients were involved. Incidents could relate to one of three psychiatric sub-specialties; acute admissions, psychogeriatric or long stay ambulant. The nurse grades who were asked to provide critical incidents were nursing officers, charge nurses, staff nurses, enrolled nurses, student nurses, pupil nurses and nursing assistants.

Unsolicited data from respondents

During the early stages of data collection it became clear that a small number of nurse respondents wished to comment on some aspect of the research generally or data collection in particular. A few comments were made by others, for example, nurse managers who facilitated the research. These comments, which were unsolicited, were not systematically recorded by the writer during the early phase of data collection or its planning. However, it soon became clear that they could provide important insights into how those involved in the project, mainly nurses, perceived the project generally and the provision of critical incidents in particular.

Comments were made in a variety of situations ranging from an interview which the writer had with a district nursing officer regarding entry to the data collection site, to a nurse who found it impossible to provide examples of critical incidents. Subsequent to recognising their potential importance the writer began to record all comments volunteered to him and which seemed to have some bearing on his research. None of the comments referred to in this paper were made by patients.

Details of the data collection technique used by the writer will be referred to only briefly, and no discussion of the collected data will be presented. Rather, the paper will focus on the unsolicited, spontaneous and "unofficial" comments which were made to the writer by 197 of the individuals involved in this study. Data collection took place during 1978 - 1979 and formed a crucial part of a study of the role of the ward based psychiatric nurse in a sample of eleven Scottish psychiatric hospitals.

A total of 251 unsolicited comments were recorded, all but ten of these were easily placed in an ad hoc classification system constructed for that purpose. The classification of comments was not subjected to any measure of reliability, for example by using independent judges. However, the reader can make a personal judgement of reliability by examining the comments presented in the paper, and how they were classified (See TABLE 1 below).

TABLE 1

Classified unsolicited and spontaneous comments (N = 251)

| Topic | Number of Comments | % |
|---|-----------------------|--------------|
| Inability to identify effective and/or ineffective incidents | 120 | (48%) |
| Difficulty in completing forms | 33 | (13%) |
| Concern about anonymity and/or confidentiality | 25 | (10%) |
| Refusal to participate | 23 | (9%) |
| Trade union concern and/or objection | 13 | (5%) |
| Relating to research method | 13 | (5%) |
| Pro research | 7 | (3%) |
| Anti research | 7 | (3%) |
| Miscellaneous | 10 | (4%) |
| | <hr/> 251 | <hr/> (100%) |

Inability to identify effective and/or ineffective incidents (N = 120)

These came from all grades of nursing staff respondents working in all three specialties, on night shift and day shift, and were frequently made after the nurse had spent twenty to thirty minutes trying to respond to the request for incidents.

Those which related to an inability to provide "effective" incidents came from all grades, levels of experience and specialties. For example a staff nurse said, "I can't think of a single thing I do which you could call effective" and a nursing assistant, "The effective things are so subtle you do not notice them, they pass without comment".

Those comments made by staff working on night duty were particularly strong in relation to an apparent inability to describe any effective aspect of their work. For example a staff nurse said, "I've been on night shift for such a long time now, I

can't think of anything effective" and a nursing assistant, "I just do the same thing all night, shovel shit out of dirty beds, you wouldn't call that effective would you?", and another "During the night they (patients) are all sleeping so we really do not do anything effective". A staff nurse commented, "I don't do anything on night duty, just change beds" and another "We really don't do anything on night duty. I could give lots of examples from day duty but nothing happens during the night". The apparent feeling of impotence in relation to influencing patient care experienced by staff on night duty was a strong and frequently reoccurring theme.

Another frequently made observation related to the relative unimportance of basic, routine or "ordinary" care given to patients. For example a staff nurse said, "The things I do are so trivial, you can't really be interested in routine nursing care" and another, "All we do here is basic nursing care. I don't see how you can really describe that as effective you just do it" and a charge nurse reported "The things I do are so trivial, you can't really be interested in routine nursing care".

A number of staff, on handing completed forms to the writer, "apologised" for only being able to write about "ordinary" nursing, while others were surprised to learn that the writer was interested in all nursing. While many nurses minimised the importance and effectiveness of their contribution to patient care, many others had difficulty in seeing the importance and effectiveness of "ordinary" nursing care.

The extent to which nurses undervalued the importance of their contribution to care may reflect the extent to which they take it for granted. This phenomenon, and its possible consequences, were described by Tomkins (1969) as follows;

"It will never happen that I look in the mirror at the end (of a morning shave) and beam at myself - 'You are an extraordinary human being - you have done it again!' We cannot be aware, let alone deeply enjoy just those achievements in which we are most skilled The price, however, may be quite severe because it results in the paradoxical consequence that we can be rewarded least by what should give us most

satisfaction, i.e. the achievements of our highest skill."

Arguably, if "routine", "basic" and "ordinary" care are to be undervalued by nurses, then the existence of nursing as a profession is being seriously questioned.

Others denied the existence of ineffective nursing care. For example a charge nurse reported, "I haven't filled in any ineffective forms. If any nurse has done anything which is ineffective he either hasn't been properly taught, the fault of the school, or he should have been weeded out and dismissed a long time ago". A similar view being expressed by a nursing officer "I don't believe that anything nurses do is really ineffective" and by a nursing assistant, "You just assume the things you do work".

A number of staff suggested that no thought was given as to whether or not activities were effective or ineffective. For example a charge nurse said, "You can never say whether a thing is effective or ineffective", and an enrolled nurse, "Effective or ineffective, it's something you just never think about".

The difficulty which the nurses making the above comments had in identifying specific effective/ineffective nursing activities may be indicative of similar difficulties being experienced by a larger population of nurses. Such difficulties, even if they exist in numbers no greater than the nurses who expressed them, raise fundamental problems in relation to what is now commonly referred to as "the nursing process". This approach to care demands that nursing activities be described in specific terms, and that nursing be evaluated. It might be speculated that the relative lack of success in implementing the nursing process, in the United States, Kirwin (1980) and in the United Kingdom Cormack (1980) may be partly due to the inability of nurses to evaluate nursing intervention in terms of it being effective/ineffective.

Difficulty in completing forms (N = 33)

Two major reasons were given to explain difficulty in placing information (known to the respondent) on paper. A number of nurses said that talking about their work would have been preferable to writing about it. For example a nursing assistant told the writer, "I'd much rather talk about my job than write about it" and a pupil

nurse, "It's having to sit down and write about it; that's the problem" and a staff nurse, "I know what I want to say but I just can't get it on paper".

Others expressed difficulty or inability to fill in the forms without having some hours or days in which to think of a reply. One example was given by an enrolled nurse, "I'm sorry, if you had given me a day's warning I could have helped you".

That nurses generally found the provision of written critical incidents difficult became more evident as the data collection proceeded, two major problems appearing to exist.

Firstly, respondents had difficulty in isolating specific and well circumscribed elements of care, given to individual patients, from the total care given to an individual or groups of individuals. Indeed, some nurses said that "the nursing routine", collective care given to a number of patients, was effective, others said that they couldn't isolate a specific example to write about.

Secondly, respondents had much difficulty in describing an activity in terms of the outcome being effective or ineffective. Many saw nursing care as being "just given", with little attention being paid to its effectiveness or ineffectiveness.

The above problems experienced by respondents also have fundamental implications for the development of contemporary approaches to nursing in the shape of what is commonly referred to as the "nursing process" which demands that the outcome of nursing care be evaluated in terms of its effectiveness/ineffectiveness.

Thus, the existing difficulties which many nurses have with conceptualising individualised care and its component parts, along with the inability which many have to measure the effectiveness of care, must be resolved before the nursing process can be implemented.

Concern about anonymity and/or confidentiality (N = 25)

All potential respondents were given firm assurances regarding the confidentiality of the information being sought, and of the anonymity of the respondents. The number of unsolicited comments made by actual or potential respondents was small but tended to reflect strong suspicions or misgivings being experienced by them. Because

of the unsolicited nature of the comments, and the extreme sensitivity of the subject, it is impossible to know the extent, or strength of feelings of concern regarding anonymity and confidentiality held by the respondents.

A nursing officer refused to participate and described a previous involvement with a research project which influenced her decision not to do so; saying to the writer, "As far as the confidentiality side of things is concerned you might find that some nurses are a bit suspicious of this sort of thing. They were asked to fill in forms anonymously two years ago regarding aspects of their work. The nurses thought the forms would be anonymous and confidential but the administration staff in this office put marks on the forms prior to their distribution, these marks being used to identify who filled in which form."

In all hospitals, including the above, some comment was made which reflected a strong anxiety about the truthfulness of the assurances given about anonymity and confidentiality. For example a staff nurse asked, "When you get these forms back do you discuss them with the nursing administration" (the writer replied "No, the information I get is completely anonymous and confidential"). The staff nurse replied, "I know our names are not on the forms but you could take them to the administration staff and they would recognise my writing. Also, they could calculate back using the number of days since the incident happened, look up the "off duty" and find out who was on duty on that date, they would then know the nurse I was referring to in the ineffective incident".

This concern regarding the data being shared with the nursing administration staff was reported on a number of occasions. On one occasion the writer was given completed forms by a staff nurse and reminded not to take them to the nursing officer for discussion. The "writing down" of ineffective incidents was something which concerned some staff. A staff nurse commented, "There are so many ineffective things I could tell you about but I'm not going to write them down" and a charge nurse stated "I'm not going to put anything in writing".

While many of the anxieties were general, a number were clearly concerned about the possibility of the researcher sharing the data with nursing administrators. Bearing in mind the close relationship which invariably exists between nurse researcher and nurse administrators, in relation to gaining access to research sites and to individual nurse respondents, the possibility of potential respondents being suspicious of the researchers' relationship with the nursing administration can be problematical. However, these comments may reflect a distrust of nurse administrators rather than of the nurse researcher.

Refusal to participate (N = 23)

Not all nurses who refused to participate gave reasons or made a comment. Indeed a number of nurses sat for twenty to thirty minutes with the forms without filling them in. However the following examples may give some indication of the reasons for refusal. The first example indicates how the refusal of one charge nurse influenced the participation of the five staff who had joined her to meet with the writer, she said, "I have heard about you being here and I don't think what you are doing will be of any use. We already know what we are doing so why fill in forms to tell you about it. Anyway I don't think that our work is anything you can write about. I cannot speak for my staff of course (five nurses had accompanied her) but I'm not going to fill in these forms". The charge nurse left accompanied by her five staff, two of whom appeared to leave reluctantly.

Some nurses simply refused to participate and gave no reasons; for example, enrolled nurse, "I'm sorry, I'm not going to fill in these forms".

Some staff gave a reason for not participating which mainly related to the lack of time or pressure of work in the ward. For example, charge nurse, "I don't really have time to help, I'm short staffed" and charge nurse, "I don't have time to do this, I have forty old ladies to look after back in the ward".

Nurses who refused to participate, or who could not do so, were not pressed into participation. Indeed, such nurses were made to feel that non-participation was acceptable to the writer and something which they should not worry or feel concerned about.

Trade union concern and/or objection (N = 13)

The writer had no formal contact with trade unions, or other staff organisations, during the phase of gaining entry to research sites, or during data collection. It was assumed that, where contact with staff organisations was required, this need would be recognised by the senior nursing administrators, for example the divisional nursing officer, through whom entry was arranged. It was known that, in relation to some hospitals, the major staff organisation had been informed or consulted about the proposed research. It was also known that, in relation to some other hospitals, the major staff organisations had not been consulted or informed.

The number of comments made to the writer and relating to trade unions was small (5%), however it was known that potential influence which such organisations exerted on those making decisions on entry to research sites was considerable. Subsequently, the writer formed the view that the role of trade unions and other staff organisations for example the Royal College of Nursing, in relation to nursing research generally and access to field sites in particular, urgently requires investigation and clarification.

One example of trade unions influence was in relation to one hospital participating in the study where the senior nurse in the hospital informed the writer that, "The officers of the major trade union have told staff not to participate in your study. They have told the staff that you are part of a senior management "plot" to provide evidence of the need for less staff". Subsequently, numbers of staff equal to those in similar size hospitals participated in the study. However on the last day of data collection two nurses (a pupil nurse and a nursing assistant) informed the writer that they were not participating because his being part of the management "plot" to reduce staff levels. After a prolonged and detailed assurance by the writer of the real purpose of the study both nurses participated.

In another hospital a nursing officer informed the writer that, "You won't get any respondents from ward "X". I've spoken to the charge nurse there, he is chairman of the major trade union at this hospital, and he is opposed to anything remotely associated with

management. If it's voluntary, he won't participate and he'll encourage his staff to refuse also".

The ability of trade unions to be used as a means enabling nurses to avoid being involved in nursing research was implied by the following statement by a senior nursing officer, "We have a heritage of endemic suspicion among psychiatric nurses. If nurses are asked to put anything on paper they are very reluctant to do so. This is particularly so of male nurses who are more suspicious and militant about this sort of thing than female nurses, they are not slow to involve the trade union if necessary".

In relation to another hospital, the district nursing officer had a number of very specific things to say in relation to the role of the trade unions in the hospital to which access was being sought. During an interview at which access was being confirmed the district nursing officer said, "I must apologise for the long delay in finalising the permission for you to collect data in hospital X. The delay has been due to protracted discussions we have had with the unions regarding your proposed research, they are very suspicious of this sort of thing. If you have any difficulty in hospital X, or if there are any serious objections, just stop at once and come and see me. You can see how thick the file of correspondence with the unions is (shows writer thick file). Some staff might even insist on bringing along their union representative when they come and see you".

On two occasions, in different hospitals, trade union stewards refused to provide critical incidents and encouraged others present to refuse also. In one hospital the steward, a nursing assistant, said in the presence of six other staff, "I am the shop steward in this hospital and I want to know how the nursing officer can release so many staff when the hospital is supposed to be short staffed. I am going to get in touch with him right away to see what this is all about". (He left without completing forms.)

In another incident the union steward encouraged the four other nurses present, including two staff nurses, not to give any examples of ineffective activities. The steward, a nursing assistant, said, "See these coloured forms (designed to contain examples of ineffective activity) I am not going to fill them in. I am letting

people know as their union steward". All five nurses left without completing any of the "ineffective" forms.

Finally, in response to a question from a chief area nursing officer asking the writer if a divisional nursing officer had consulted with the trade unions before giving the writer permission to gather data at a hospital, the writer replied that the major staff organisation had been consulted (it had in excess of 90% of nurses as members). The chief area nursing officer replied that twelve staff organisations had members at the hospital and that all would have to be consulted.

Despite the small number (13) of comments relating to trade unions it is clear that their potential role in facilitating or preventing access to hospitals for data collection is very considerable. The writer does not wish to underestimate or undervalue the role of trade unions in relation to facilitating nursing research. What is being suggested is that the role of trade unions must be recognised, described and made explicit in order that unnecessary delay, friction or mis-understanding be minimised in the future.

Relation to research method (N = 13)

These related to general or specific aspects of the research method being used. For example a chief area nursing officer attempted to place a constraint on the outcome of the research, pointing out that the writer would obtain examples of ineffective nursing activity, but that, "Psychiatric nursing is in a difficult period. I won't have anything disparaging said about it in the course of your research."

On another occasion, following permission for access to nurse and patient respondents being granted, a consultant psychiatrist arranged a twenty minute interview with the writer in which he asked for details of the research method to be used. After receiving assurances that research and ethical committees in other parts of the country had allowed access to respondents there, he "allowed" access to patients and nurses in "his" wards providing that, "..... the staff do not mind patients commenting on nursing care".

A nursing officer reminded the writer that staff had been requested to participate in the research project but had been informed in writing that it was not compulsory to do so.

A charge nurse was critical of the decision to ask patients to provide critical incidents, commenting, "You can't really rely on what psychiatric patients say."

A staff nurse recognising a limitation of the critical incident technique when reporting on the activity of others observed, "Of course, when you are looking at another person at work it is sometimes impossible to be aware of the whole circumstances relating to the activity. You don't know what that person is thinking."

Pro Research (N = 7)

Nurses of all grades commented on the value of being asked to provide critical incidents. Comments were rather general and indicated the value of being asked, for the first time ever in one instance, to critically examine the nursing activity of oneself and others. For example a student nurse said, "This gives us the much needed opportunity to comment on things which we say or do which we think are effective or ineffective." A charge nurse underlined the infrequency with which nurses have described their work in the way requested by saying, "The last time I had to say something about my work in this kind of way giving specific examples of effective care was when I was a student nurse."

A student nurse welcomed the opportunity to be made to "think" about his work, "This provides an opportunity to make us think about our work. Is it effective, ineffective, or what?"

Other comments of the same general kind were less specific and included, "This kind of thing is good" and "After I went back to my ward I thought about your questions and came up with a lot of effective and ineffective examples. Your forms got me to think."

Anti Research (N = 7)

These comments were all from trained staff: charge, staff and enrolled nurses who had strong views about the pointless nature of nursing research. For example a charge nurse refused to participate saying, "Do you really think we need research into what we are doing. We already know what we are doing." A staff nurse said, "I don't really see the point in this research stuff anyway. What happens when all this research is done - nothing." However, these negative

comments appeared to express a minority view. Many nurses including a number who felt unable to provide incidents, expressed a clear willingness to participate in the research study.

Miscellaneous (N = 10)

No further comment will be made on this group.

Conclusions

The unsolicited comments obtained from staff involved in this project give some indication of their "feeling" regarding it. While such comments came from a relatively small number of staff, they are felt to be of use in understanding the dynamics involved in some aspects of collecting research data from contemporary nurses.

As nursing becomes increasingly research based, the importance of potential nurse subjects or respondents to feel at ease when part of the research process is of paramount importance. At present, the nursing profession generally is neither research based or aware of what may be described as the "research process". It may be that, as the nursing profession becomes more aware of research and research ethics, that nurses will have less difficulty in participating in this activity.

Whilst the number of nurses who were asked by the writer to participate in this study, and refused to do so, was not systematically recorded, the refusal rate is estimated to be less than 10%. However, it may well be that the recorded comments reflect the views of a population larger than the small number of respondents who made them. Thus, some opportunity for making comments, in addition to that regarded as data, may prove useful. An important example of this are the comments made by a number of nurses who suggested that what they did was so "ordinary" that a researcher could not possibly be interested in it.

Finally, the researcher must be aware that all the factors relating to his data collection are not overt and that local circumstances may influence the outcome of his request for staff participation. An understanding of the possibility of covert and negative factors interfering with the research process may shed light on the varied difficulties which researchers experience in

collecting data.

Recommendations

Giving respondents the opportunity to make "additional comments" may well provide additional insights into areas of immediate, and less immediate, interest to the researcher. The nature of this opportunity will clearly depend on the style of data collection used, in the instance described in this paper it was verbal and occurred before, during and after data collection.

An open mind must be kept to the possibility of unsolicited data being volunteered which is of use to the researcher. Providing that its collection does not interfere with the collection of the "proper" data, or reduce the quality of the data, then it should be collected whenever possible. In short, data collection plans should be regarded as subject to extension in order to accommodate additional material.

More specifically, additional data which contribute to the understanding of nursing research generally should not be ignored. Although of minor importance to the study being undertaken, such data may add to an understanding of nursing research generally.

Problems relating to anonymity and confidentiality may well be greater than many researchers suppose, the extreme caution of some of the respondents in this study testifies to this. While no easy solution can be offered on the question of optimising belief in the promise of anonymity and confidentiality, it is a problem which has to be tackled with the utmost seriousness and vigour.

Finally, the question of the role which trade unions are to play in the decision making process relating to nursing research is one which has only recently emerged but will become more pressing. Unless a firm attempt is made now to clarify the role of the trade union, and other staff organisations, the quality and quantity of nursing research in this country may have to deteriorate before a "crisis" examination of their roles is precipitated. In anticipation of such problems arising, it is suggested that the policy makers in nursing and in staff organisations reach a mutual understanding which will maximise the very important role which each can play in relation to formulating general strategies relating to the permission

seeking researcher. In the short term, researchers seeking access to data sources, particularly nurse respondents, must develop a sensitivity to staff organisations and the role which they can play. Indeed, there may be some advantage in direct consultation between the researcher and the staff organisation becoming a feature of nursing research, as is the case in many aspects of industrial research. Undoubtedly, considerable local variation will prevent a uniform approach to the question being used. However, in being aware of a potential difficulty, it becomes easier to avoid.

APPENDIX 11

Results of inter-rater reliability (I.R.R.) Tests

| <u>INDEPENDENT</u> <u>JUDGES</u> | <u>% AGREEMENT</u> | <u>COEFFICIENT K</u> | <u>Z SCORE</u> |
|-------------------------------------|--------------------|----------------------|---------------------------------------|
| | | | <u>Areas = 4 (A,B,C & D)</u> |
| A.A. | 88 | .78 | 8.7 |
| J.S. | 80 | .51 | 4.5 |
| | | | <u>Categories</u> <u>In Area A</u> |
| A.A. | 69 | .52 | 6 |
| R.S. | 88 | .79 | 8.4 |
| | | | <u>Categories</u> <u>In Area B</u> |
| A.P. | 97 | .95 | 6.8 |
| P.F. | 97 | .95 | 6.8 |
| | | | <u>Categories</u> <u>In Area C</u> |
| R.S. | 94 | .85 | 2.81 |
| A.A. | 100 | 1.00 | 3.1 |
| | | | <u>Categories</u> <u>In Area D</u> |
| A.P. | 89 | .79 | 7.2 |
| P.F. | 87 | .73 | 6.7 |

Footnote 1

A Z score equal to or exceeding 1.96 is indicative of a level of agreement between the writer and the independent judges being significant at the 0.05 level.

A Z score equal to or exceeding 2.58 is indicative of a level of agreement between the writer and the independent judges being significant at the 0.01 level.

A Z score equal to or exceeding 3.31 is indicative of a level of agreement between the writer and the independent judges being significant at the 0.001 level.

Footnote 2

"The coefficient K is simply the proportion of chance-expected disagreements which do not occur, or alternatively, it is the proportion of agreement after chance agreement is removed from consideration" (Cohen 1960)

INDEPENDENT
JUDGES

% AGREEMENT

COEFFICIENT K

Z SCORE

Sub-categories

In Area A Category I

| | | | |
|------|----|-----|------|
| D.B. | 55 | .38 | 10.4 |
| M.W. | 66 | .61 | 15.1 |

Sub-categories

In Area A Category II

| | | | |
|------|----|-----|------|
| D.B. | 50 | .37 | 5.33 |
| M.W. | 85 | .79 | 10.3 |

Sub-categories

In Area A Category III

| | | | |
|------|-----|------|-----|
| D.B. | 100 | 1.00 | 4.4 |
| M.W. | 100 | 1.00 | 4.4 |

Sub-categories

In Area A Category IV

| | | | |
|------|----|-----|-----|
| D.B. | 48 | .37 | 4.1 |
| M.W. | 50 | .43 | 5.8 |

Sub-categories

In Area A Category V

| | | | |
|------|----|-----|------|
| D.B. | 67 | .46 | 2.85 |
| M.W. | 70 | .52 | 3.5 |

Sub-categories

In Area B Category I

| | | | |
|------|-----|------|------|
| A.P. | 100 | 1.00 | 3.33 |
| P.F. | 86 | .77 | 2.69 |

Sub-categories

In Area B Category II

Test not performed since the number of Sub-categories (1) offered no choice of classification.

Sub-categories

In Area B Category III

| | | | |
|------|----|-----|------|
| A.P. | 64 | .39 | 2.29 |
| P.F. | 85 | .78 | 4.42 |

Sub-categories

In Area C Category I

| | | | |
|------|----|-----|------|
| C.B. | 91 | .76 | 1.96 |
| R.S. | 91 | .78 | 2.58 |

| <u>INDEPENDENT</u> <u>JUDGES</u> | <u>% AGREEMENT</u> | <u>COEFFICIENT K</u> | <u>Z SCORE</u> |
|-------------------------------------|--------------------|----------------------|--|
| | | | <u>Sub-categories</u> In Area C Category II |
| C.B. | 58 | .46 | 5.66 |
| R.S. | 77 | .69 | 8.37 |
| | | | <u>Sub-categories</u> In Area D Category I |
| P.F. | 79 | .72 | 8.63 |
| A.P. | 86 | .77 | 10.45 |
| | | | <u>Sub-categories</u> In Area D Category II |

Test not performed since the number of
Sub-categories (1) offered no choice of
classification.

Nursing assistant training programme

Introductory Course

Brief Outline of Management Structure of Hospital
Hospital Departments
Personal Hygiene
Reporting of Accidents
Complaints Procedure
Confidentiality

Bedmaking. Routine and Specific.

Handling of Soiled Linen
Disinfection of Bed and Linen
Lifting and Turning of Patients

Admission of Patients, Ambulant and non-ambulant

Care of Clothing and Valuables
Dressing and Undressing patients
Bed Bathing
Bathing in Bathroom
Care of Hair, Finger and Toe Nails
Care of Dentures

Toilet Training, including use of Sanichairs and Commodes

Care of Incontinent Patient
Obtaining simple specimens urine, faeces and vomit

Pressure areas, Care and Observation

Care of Dying and Last Offices

Serving of Meals, Feeding of Patients

Discharge of Patients

Escorting of Patients to Hospital

Discharge
O.T. and Rec. Ther. etc.

Keeping of Records, Unit Cards etc.

Ward Economy

Cleaning of cupboards
Cleaning of patients lockers

Answering Telephone

Relationships with other members of Ward
Meeting Visitors

General observation of patients

APPENDIX 13

Nursing assistant job description

RESPONSIBLE TO:- The Charge Nurse

REPORTS TO:- The Charge Nurse

SUMMARY OF DUTIES:- The range of duties considered appropriate is set out below, but will vary with the type of Ward, the degree of patient dependency and the experience and training of the Nursing assistant.

He/she may also assist with other procedures and techniques at the discretion of the Charge nurse.

1. Assisting with admission and discharge of patients. Appropriate duties may include listing and care of clothing and assisting with undressing.
2. Weighing patients and recording same.
3. Assisting with the stripping and making of occupied beds.
4. Stripping and making unoccupied beds of ambulant patients.
5. Assisting with the preparation of patients for meals, serving drinks and beverages.
6. Assisting with the service of meals.
7. Assisting with feeding of patients in all age groups.
8. Cleaning and preparing nursing equipment including non-routine cleaning of baths and sanitary utensils including bins and buckets after use.
9. Assisting with bathing - in bed and in the bathroom - and with turning and moving of patients. Assisting with hygiene including hair care, teeth and nails.
10. Assisting with Last Offices.
11. Assisting with care of pressure areas.
12. Assisting with changing of napkins (where applicable).
13. Giving out and removing bed pans with assistance when necessary. Giving and removing urinals, tooth mugs and sputum containers. Cleaning and replacing same as necessary.

14. Obtaining simple specimens and assisting with urine tests.
15. Assisting ambulant patients with dressing, undressing, going to W.C. and using sanichairs and commodes.
16. Assisting with transfer of patients to other departments or wards and on dismissal from hospital.
17. Answering telephone - take, record and transmit messages.
18. Participating in occupational, social and diversional therapy including recreation, sport and play. (Where applicable)
19. Cleaning and tidying storage cupboards - excluding cupboards for Controlled Drugs and Poisons.
20. Tidying the contents of patients' lockers.
21. Assisting with the keeping of routine ward records, e.g. weight charts, fluid balance charts.
22. Chaperone patients in wards and clinics and in ambulances, where appropriate and reporting back relevant information.
23. Reporting to the Charge Nurse any change in patients' conditions and any untoward incidents and accidents.
24. Attending In-Service training courses as arranged.
25. Be aware of the District's Standing Orders and other relevant guidance pertaining to Fire Precautions.

This Job Description is not intended to be a complete list of the duties and responsibilities, but it indicates the main ones attached to the post.

APPENDIX 14

Nursing assistant's assessment

INSTRUCTIONS

Please tick in appropriate column.

V.G. = VERY GOOD

G = GOOD

F = FAIR

P = POOR

| | V.G. | G. | F. | P. | REMARKS |
|---------------------------------------|------|----|----|----|---------|
| ATTITUDE TOWARDS PATIENTS | | | | | |
| ATTITUDE TOWARDS VISITORS | | | | | |
| ATTITUDE TOWARDS IMMEDIATE COLLEAGUES | | | | | |
| ATTITUDE TOWARDS SENIOR COLLEAGUES | | | | | |
| PUNCTUALITY | | | | | |
| OBSERVATION AND REPORTING | | | | | |
| RELIABILITY | | | | | |
| PERSONAL APPEARANCE | | | | | |
| PROFESSIONAL INTEREST | | | | | |
| PRACTICAL APPLICATION | | | | | |
| ADAPTABILITY TO WARD OR DEPARTMENT | | | | | |
| REACTION TO GUIDANCE/DISCIPLINE | | | | | |

REPORTING OFFICER'S GENERAL REMARKS

REPORTING OFFICER'S SIGNATURE

DATE

COMMENTS AND SIGNATURE OF PERSON REPORTED ON

DATE

UNIT NURSING OFFICER'S REMARKS AND SIGNATURE

DATE

Pupil nurse training programme
(General Nursing Council for Scotland 1973)

PRINCIPLES AND PRACTICE OF NURSING

- The Hospital : Its aims and functions.
Hospital etiquette.
- The Nurse : Essential qualities and general duties.
National Health Service - the place of the nurse
in this structure.
- Nursing : Historical survey; Nurse/Patient relationship.
Ethics of Nursing; the International Code of
Nursing Ethics.
- The Patient : The patient is an individual.
The confidential nature of the work.
Reception and observation of the patients and
orientation of the unit.
Approach and attitude to patient's relatives and
other visitors.
Some of the legal aspects as they affect patients
and nursing staff.

Basic Nursing Care of the Patient in all Age Groups

Special Care of the Patient (Physical/Psychological)

Childhood
Adolescence
Adulthood
Old Age

Therapeutic Procedures - including drugs

Community Care

Personal and Community Health
Rehabilitation

Human Biology

An elementary knowledge of the structure and functions of the human
body in health.

APPENDIX 16

Assessment record for student and pupil nurse

STANDARDS OF SAFETY

Columns to the left of centre are above average standard
Columns to the right of centre are below average standard

x

Average

Y

Pays close attention to detail

Consistently prompt in reporting relevant information

Very observant and takes appropriate action

Consistently takes measures to prevent the occurrence or spread of infection

Is able to deal with emergency and/or stressful situations

Shows understanding of accident prevention procedures

Always takes precautions for safe storage and administration of medication

COMMENTS :

[illegible]

Work lacks detailed care and attention

Sometimes forgets to pass on information

Sometimes puts patient at risk by failing to be observant

Does not appreciate the dangers of infection
or its spread

Has difficulty in coping with emergencies
and/or stressful situations

Is careless in use of equipment, and in observing safety regulations

Does not take adequate care when handling medications

Columns to the left of centre are above average standard
Columns to the right of centre are below average standard

X

Average

Y

Shows excellent ability to plan and complete own work

Is outstanding in ability to organise and supervise work of others

Grasps essentials very quickly

Successfully anticipates the requirements of new situations and takes appropriate action

Demonstrates an appropriate degree of initiative and self-reliance

Is thoroughly reliable in record keeping

Regularly produces well written and concise reports

COMMENTS:

| | | | | |
|--|--|--|--|--|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Has not yet learned to organise own work effectively

Is not able to organise and supervise work of others

Has difficulty in recognising essentials

Has difficulty in recognising implications of new situations

Requires a great deal of support to cope with work assigned to her/him

Inclined to be careless and dilatory in recording necessary clinical data

Written reports tend to be incomplete and poorly expressed

PROFESSIONAL AND
PERSONAL ATTITUDES

Columns to the left of centre are above average standard
Columns to the right of centre are below average standard

X

Average

Y

Is consistently conscientious and
enthusiastic in all aspects of her
work

Shows consideration for patients and
others in personal appearance

Takes action to protect patients from
excessive noise

Is effective and self controlled even
in stressful situations

Always punctual in arriving for duty

Accepts responsibility for duties
within competence

Shows interest in new developments in
patient care

COMMENTS:

| | | | | |
|--|--|--|--|--|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Appears indifferent and lacks interest

Disregards consideration for patients in
personal appearance

Tends to be noisy and does not appreciate
the patients need for a quiet environment

Is easily upset by unusual or difficult
situations

Frequently late in arriving for duty

Attitude to duties is immature, lacking in
purpose

Tends to be concerned only with essential
work on hand

SKILLS IN COMMUNICATION

Columns to the left of centre are above average standard
Columns to the right of centre are below average standard

| X | Average | Y |
|--|---------|---|
| Regularly makes a useful contribution in group discussion | | Finda it difficult to be a contributing group member |
| Can be relied upon to carry out instructions accurately and without supervision | | Needs more supervision than most in carrying out instructions assigned to her/him |
| Works amicably with others as a member of a team | | Has difficulty in working with nurse colleagues and is sometimes not accepted as a member of the team |
| Responds well to instruction/advice/criticism | | Resents criticism and is reluctant to accept advice |
| Is consistently courteous and helpful to co-workers | | Appears off-hand and casual in dealing with co-workers |
| Is outstanding in dealing tactfully and politely with visitors, relatives and others | | Lacks understanding and consideration towards visitors, relatives and others |
| Uses opportunities to guide and instruct patients/co-workers/relatives | | Tends not to see opportunities available for teaching |

COMMENTS:

Enrolled nurse job description

Role : Enrolled Nurse (Day Duty)

Responsible to : Charge Nurse (Grade 6)

Reports to: : Charge Nurse/Staff Nurse.

FUNCTIONS:

PROFESSIONAL:

1. Supervising professional work of junior nursing staff in the absence of staff nurse and charge nurse.
2. Assisting in preparation and receipt of Nursing Reports.
3. Checking, witnessing and administering drugs.
4. Assisting Medical Staff and implementing the prescribed treatment programme under the direction of Charge Nurse.
5. Reporting condition of patients to Senior Nursing Staff and Medical Staff.
6. Carrying out nursing procedures and treatment.
7. Assisting Registered Nurses in the teaching of Students and Pupils.
8. Maintaining personal contact with patients through participation in treatment programmes.
9. Assisting with patients' meals and special diets. Participating in meal service.
10. Communicating with relatives of patients and with visitors, as directed by Senior Nursing Staff.
11. Participating in Ward Meetings with patients, nursing and Medical Staff.
12. Keeping abreast of new developments in treatment and drugs in the Psychiatric Field.
13. Assisting with patients' daily programme, e.g. Occupational and Social Therapies, Group Therapy.

ADMINISTRATIVE:

14. Assisting in reception of patients in accordance with standing instructions.
15. Assisting in maintaining good order and cleanliness in the ward.
16. Assisting in control of drugs and dressings kept in the ward.
17. Participating in maintenance of ward stores and equipment with due care and economy.
18. Participating in care of patients' monies, valuables and other property.
19. Assisting in the discharge of patients' and their after-care.
20. Co-operating with all nursing and other Hospital Personnel and assisting in their activities at ward level.
21. Reporting on ward affairs to Nursing Officer in absence of staff nurse/charge nurse.
22. Assisting with the care and distribution of Patients' mail.

PERSONNEL:

23. Assisting in introducing new members of staff to ~~their~~ duties and also to patients and to other members of staff.
24. Reporting to Charge Nurse on performance of junior ^{members} of staff.

APPENDIX 18

Enrolled nurse, staff nurse and charge nurse assessment schedule

| ASSESSMENT OF QUALITIES AND PERFORMANCE OF DUTIES | | Remarks |
|---|---|---------|
| <p>The remarks column should be used to supplement the ratings. Please put an x in the appropriate box to indicate the degree of ability shown by the officer during the assessment period.</p> | | |
| PROFESSIONAL COMPETENCE | | |
| 1. Awareness of the total needs of patients both clinical and personal | a) Outstanding b) Very good c) Good d) Fair e) Poor | |
| 2. Maintenance of professional standards | a) Outstanding b) Very good c) Good d) Fair e) Poor | |
| 3. Awareness of advances in nursing techniques | a) Outstanding b) Very good c) Good d) Fair e) Poor | |
| INTERPERSONAL RELATIONSHIPS | | |
| 1. Co-operation with senior nursing colleagues | a) Outstanding b) Very good c) Good d) Fair e) Poor | |
| 2. Co-operation with junior nursing colleagues | a) Outstanding b) Very good c) Good d) Fair e) Poor | |

3. Relationships with non-nursing colleagues
- a) Outstanding
b) Very good
c) Good
d) Fair
e) Poor
4. Co-operation with all visitors to the hospital
- a) Outstanding
b) Very good
c) Good
d) Fair
e) Poor
5. Contacts with the community and other organisations
- a) Outstanding
b) Very good
c) Good
d) Fair
e) Poor

MANAGERIAL COMPETENCE

1. Ability to plan and organise
 - a) Outstanding
 - b) Very good
 - c) Good
 - d) Fair
 - e) Poor
2. Ability to manage staff
 - a) Outstanding
 - b) Very good
 - c) Good
 - d) Fair
 - e) Poor
3. Exercise of judgement
 - a) Outstanding
 - b) Very good
 - c) Good
 - d) Fair
 - e) Poor
4. Acceptance of change
 - a) Outstanding
 - b) Very good
 - c) Good
 - d) Fair
 - e) Poor
5. Willingness to delegate
 - a) Outstanding
 - b) Very good
 - c) Good
 - d) Fair
 - e) Poor

Remarks

- | | |
|--|---|
| 6. Degree of initiative | a) Outstanding b) Very good c) Good d) Fair e) Poor |
| 7. Recognition of ability and development of staff potential | a) Outstanding b) Very good c) Good d) Fair e) Poor |
| 8. Appreciation of financial responsibilities | a) Outstanding b) Very good c) Good d) Fair e) Poor |
| 9. Success in communication on paper | a) Outstanding b) Very good c) Good d) Fair e) Poor |
| 10. Success in communication orally | a) Outstanding b) Very good c) Good d) Fair e) Poor |

Summary of student nurse training programme
(General Nursing Council for Scotland 1973)

Syllabus for Psychiatric Nursing

Nursing

The historical background of nursing and the place of the nurse in the National Health Service. The hospital and the community.

Human relationships, nursing ethics, hospital etiquette.

Principles and practice of nursing of the psychiatric patient

Psychiatric hospital: Its aims and functions

Psychiatric nurse: Essential qualities and general duties

Psychiatric nursing: Historical survey, nurse-patient relationship

Psychiatric illness: Body-mind relationship
An introduction to hereditary and environmental factors.

Psychiatric patient: The patient as an individual.
The confidential nature of the work.
Reception and observation, orientation of patients, legal aspects affecting patients and nurses.
Common symptomatology of psychiatric illnesses

Care and management of patients presenting special problems e.g. Adolescent, elderly, suicidal and those with degraded and depraved habits.

The hospital as a therapeutic community e.g.

The ward programme

Ward management e.g.

Care and use of hospital equipment and

Economy in use of hospital supplies

Transfer and discharge

General care of the patient e.g.

Routine bed making, bathing in bed, care of pressure areas and preparing and serving meals.

Nursing procedures e.g.

Administration of drugs

Treatment

Elementary psychology Development and behaviour in;
childhood, adolescence, adulthood and old age.

The aims and functions of the Mental Health Services.

Introduction to personal and community health e.g.
personal hygiene, domestic and communal health, heating, housing,
infection and nutrition.

Human biology e.g.

The cell, nutrition, elimination, human anatomy, respiration and
reproduction.

First aid e.g.

General principles of first aid, shock, burns, fractures, poisoning,
frost bite and reception of accident cases.

Advanced nursing e.g.

Physical and radiological examination, ward administration, ward
teaching, maintenance of equipment, ordering stores and procedures
in case of fire or accidents. Special duties relating to patients
property and correspondence. Night nursing and night reports.
Physical methods of treatment, discharge arrangements and rehabilitation.

Methods of treatment including tepid sponging, gastric lavage,
theatre techniques, stitching and recording blood pressure.

Psychology e.g.

Instinctive behaviour, conscious behaviour and unconscious behaviour.
Effects of hospitalisation on the patient and family.
Heredity and environment.

Materia medica and therapeutics

Psychiatry e.g.

Historical survey, psychopathology, psychiatric illness and mental
subnormality.

Legal and administrative aspects e.g.

The National Health Service, The Mental Health (Scotland) Act 1960,
the property and civil rights of the patient and crime and mental
disorder.

Applied human biology

Physical diseases and disorders e.g. relating to
inflammation, new growths, skin, nervous system, endocrine glands
and the eye and ear.

Anaesthetics

APPENDIX 20

Staff nurse job description

ROLE: : STAFF NURSE (Psychiatric)
GRADE : STAFF NURSE Grade 5.
RESPONSIBLE TO : Charge Nurse/Ward Sister
REPORTS TO : Charge Nurse/Ward Sister
QUALIFICATIONS : Registered on appropriate part of the Register.

FUNCTIONS:

A. Professional

1. Supervising professional work of Junior Nursing Staff.
2. Preparing reports for, and receiving reports from the night nurse.
3. Maintaining custody of dangerous drugs: checking and witnessing administration of drugs.
4. Assisting medical staff and ascertaining medical treatments.
5. Reporting condition of patients to medical staff and, when necessary, to Ward Sister/Charge Nurse, and receiving instructions.
6. Carrying out some nursing procedures and treatments.
7. Teaching of student and pupil nurses.
8. Training of qualified nursing staff in nursing and ward management.
9. Directing the training of other ward staff.
10. Maintaining personal contacts with patients through ward rounds, conversations etc.
11. Arranging for patients' meals and special diets and participating in meal service.
12. Communicating with relatives and patients and with visitors as required.

B. Administrative

13. Organising reception of patients and nursing in accordance with any standing instructions.
14. Maintaining good order and cleanliness in the ward.
15. Arranging systematic practical instruction of student and pupil nurses in accordance with the requirements of the General Nursing Council.
16. Controlling drugs and dressing kept in the ward.
17. Maintaining ward stores and equipment; and requisitioning with due economy, provisions and other supplies (If no Imprest System) and repairs and replacement of equipment.
18. Arranging care of patients' property and controlling the distribution of patients' mail.
19. Assisting medical staff in the discharge of patients and their after-care.
20. Assisting medical staff in observing the legal requirements of the Mental Health Act.
21. Co-operating with other nursing units and other hospital departments (and where necessary co-ordinating their activities at ward level), e.g. admissions, catering officer, chaplains, medical records, occupational therapy, psychiatric social workers, pathology, pharmacy, physiotherapy, transport, X-ray.
22. Rendering returns required by any branch of the hospital administration including notification of patients' deaths and mishaps.
23. Reporting on ward affairs to Ward Sister/Charge Nurse.

C. Personnel

24. Introducing new member of staff to their duties.
25. Counselling ward staff and nurses in training.
26. Reporting on qualified and other nursing staff to Ward/Charge Nurse.
27. Recording progress of students and pupil nurses and reporting thereon to Ward Sister/Charge Nurse.

Charge nurse job description

ROLE : Charge Nurse in control of a ward by day

RESPONSIBLE TO : Nursing Officer (Grade 7)

REPORTS TO : Nursing Officer (Grade 7)

MINIMAL QUALIFICATIONS : Registered on the appropriate part of the register for Psychiatric Nursing.

Attended or willing to attend First Line Management Course.

FUNCTIONS:

PROFESSIONAL:

1. Supervising professional work of nursing staff.
2. Preparing reports for and receiving reports from night nursing staff.
3. Maintaining custody of controlled and scheduled drugs, ensuring the agreed procedure for checking and witnessing administration of drugs is followed.
4. Assisting medical staff and directing the prescribed treatment Programme.
5. Reporting condition of patients to medical staff, and when necessary, to Nursing Officer (Grade 7) and receiving instructions.
6. Carrying out nursing procedures and treatments.
7. Devising and carrying through training programmes for student and pupil nurses.
8. Training qualified nursing staff in nursing and ward management.
9. Directing the training of other ward staff.
10. Maintaining personal contact with patients through participation in treatment programmes.
11. Arranging for patients' meals and special diets and participating in meal service.
12. Communication with relatives of patients and with visitors, as required.

ADMINISTRATIVE:

13. Organising reception of patients in accordance with standing instructions.
14. Maintaining good order and cleanliness in the ward.
15. Arranging systematic practical instruction of student and pupil nurses in accordance with the requirements of the General Nursing Council.
16. Controlling supplies of drugs and dressings kept in the ward.
17. Maintaining ward stores and equipment: and requisitioning with due economy, provisions and other supplies (if no imprest System) and repairs and replacement of equipment.
18. Arranging care of patients' property and controlling the distribution of patients' mail.
19. Assisting medical staff in the discharge of patients and their after-care.
20. Assisting staff in observing the legal requirements of the Mental Health Act.
21. Co-operating with nursing units and other hospital departments and, where necessary, co-ordinating their activities at ward level.
22. Rendering returns and reports, as required.
23. Reporting on ward affairs to Nursing Officer (Grade 7).

PERSONNEL:

24. Introducing new members of staff to their duties.
25. Counselling ward staff and nurses in training.
26. Reporting on qualified and other nursing staff to Nursing Officer (Grade 7)
27. Recording progress of students and pupil nurses and reporting thereon to Nursing Officer (Grade 7).